Comprehensive HIV Prevention Plan for the State of Idaho

Years 2001-2003

Developed by the Idaho HIV Prevention Planning Group

Submitted by the STD/AIDS Program
of the Idaho Department of Health and Welfare

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TABLE OF CONTENTS

INTRODUCTION

The purpose of the *Comprehensive HIV Prevention Plan for the State of Idaho: 2001-2003* is to define HIV prevention strategies that are locally responsive to Idaho's AIDS epidemic. The Plan outlines the HIV prevention needs in the state, portrays who is most at-risk of HIV infection, and determines strategies for reducing HIV infection among these groups.

The priorities contained in the Plan have been decided by the Idaho HIV Prevention Planning Group (IPPG). The 32-member IPPG is composed of persons from around the state who are affected and infected by HIV/AIDS, as well as HIV prevention providers and those with expertise in the design and evaluation of disease prevention programs.

The IPPG, through review of epidemiological data, has determined that there are three population groups at greatest risk of HIV infection in Idaho: men who have sex with other men (MSMs), women with high risk partners, and injection drug users (IDUs).

During 2000, the IPPG focused on assessing and responding to the HIV prevention needs of MSMs. The Plan reflects this effort. In 2001, the IPPG will assess the prevention needs of women at risk and recommend interventions that will best reach this population. Then in 2002, the IPPG will repeat this planning process for IDUs.

Historically, Idaho's HIV prevention efforts have emphasized community education and HIV counseling and testing. However, research results are showing that other types of interventions are effective in preventing the transmission of HIV. Beginning in 2001, the state's HIV prevention providers will be conducting more activities that reach priority populations through individual and group level activities. These interventions are described further in the Plan.

Year 2001 will also bring an increase emphasis on the evaluation of Idaho's HIV prevention work. At the state and local level, data will be gathered on who HIV interventions are reaching, the quality of the interventions, and if prevention efforts are having an impact on behaviors that put persons at-risk of HIV infection.

EPIDEMIOLOGICAL PROFILE

Executive Summary

Through December of 1999, a total of 1,001 cases of HIV have been reported to the Idaho Department of Health and Welfare. Of these 1,001 people, 479 have been diagnosed with AIDS while living in Idaho. Thirty-nine of Idaho's 44 counties have reported at least one case of HIV or AIDS. During 1999 there were 18 cases of AIDS reported and 43 cases of HIV. The cumulative death rate is 349 for a fatality rate of 34.8 percent.

Males make up 83.7 percent of the reported cases of HIV/AIDS. Forty percent of the reported HIV cases are between the ages of 30 –39 and 37 percent are between 20-29. Forty-five percent of the reported AIDS cases are between 30-39, and 15 percent are between 20-29. The people diagnosed with AIDS under the age of 30 were probably infected in their teens or early twenties. Idaho has not experienced the increase in cases among racial/ethnic minority groups seen in other states. Eighty-seven percent of the reported HIV cases and 90 percent of the reported AIDS are identified as white.

Male-to-male transmission remains the most prevalent risk factor with 45 percent of the HIV cases and 59 percent of the AIDS cases reporting this exposure category. Injection drug use (27 percent) and heterosexual contact (23 percent) are the second and third most prevalent risk factors, respectively.

Heterosexual transmission has increased from 8 percent in 1997 to 22 percent in 1999. The number of women reported with HIV has gone from 15 percent to 23 percent during this time frame.

Introduction

Epidemiologic profiling of communicable diseases is an essential component in the development of effective prevention and control plans. It serves as a cornerstone for program activities and provides the measure of success of intervention efforts. For this purpose the Idaho Department of Health and Welfare STD/AIDS Program has prepared the Epidemiologic Profile of HIV in Idaho.

This report is based on guidelines suggested by the Centers for Disease Control (CDC) for developing an epidemiologic profile for HIV prevention community planning. This report:

- Reflects the magnitude of the current epidemic in Idaho;
- Describes the distribution, determinants, and trends of the HIV epidemic in defined populations; and
- Identifies characteristics of persons at high risk of HIV infection who need prevention services.

Idaho has been divided into districts for HIV-prevention community planning purposes. These districts encompass the same areas as the seven public health districts. These districts are reflected in the diagram on page 30 of this report.

In developing this epidemiologic profile of HIV, four key questions were addressed:

1. What are the sociodemographic characteristics of the populations?

    - Provides background on diversity of population and context for assessing potential HIV impact relative to other regions and the nation.

2. What is the impact of HIV/AIDS on the population?

    - Examines the extent of existing HIV infection in population groups within the state.
    - Provides a basis for comparison with national data and a framework for closer examination of impact among specific population groups.

3. Who is at risk for becoming infected with HIV?

    - Provides regional information on HIV infection among population groups at high risk for HIV infection.
    - Helps planning groups identify populations most affected in their own regions.

4. What is the geographic distribution of HIV infection?

    - Provides information about possible locations for prevention activities that may offer access to individuals at high risk for HIV.
    - Supports decisions about priorities among HIV prevention needs and possible interventions.

Data Quality

Epidemiologic data must be considered in the context of their strengths and limitations, how they were collected, and their validity. CDC has established an AIDS Case Surveillance Definition that is used to describe the late stages of HIV disease. As a result of this definition, AIDS case data are one of the few HIV-related data items consistently available on a population-wide basis in all states by sex, race, ethnicity, age, and mode of HIV exposure.

Approximately 50 percent of persons infected with HIV are diagnosed with AIDS within ten years of infection. New drugs could lengthen this period. Because of the time between HIV infection and the occurrence of AIDS-defining conditions, AIDS case data do not necessarily represent the characteristics of persons with more recently acquired infections. However, changes in the characteristics of HIV-infected persons may be mirrored by AIDS trends.

Analysis of AIDS cases by year of diagnosis is affected by routine delays in reporting (time between AIDS diagnosis and report to the STD/AIDS Program). Although the majority of Idaho HIV and AIDS cases are reported promptly, there are likely to be cases which have yet to be reported. To minimize the effects of reporting delay, cases are analyzed in this document by year of report.

Expansion of the AIDS surveillance case definition for adults and adolescents was implemented on January 1, 1993. As a result, in 1993, persons with conditions that were not previously eligible for reporting were higher than it otherwise would have been. Another anticipated effect of the expanded AIDS case definition was the increase in the number and percent of adult cases reported with no identified risk (NIR). There is no evidence to suggest that new or unusual modes of HIV transmission are responsible for the increasing proportion of NIR cases. Nationally, at the end of 1993, 7 percent of the cases reported during the year were classified as NIR. By comparison, at the end of 1994, 12 percent of the year's reported cases were NIR. Most likely the expanded case definition affected the availability of adequately documented risk factors.

Users of this Epidemiologic Profile of HIV in Idaho are encouraged to:

- Understand what is being looked at, even if it means asking questions.
- Recognize the limitations of the data.
- Not over-interpret small changes or differences.
- Look for inconsistencies with other sources of information.
- Remember what the numbers represent (e.g. number of cases, rates, percent).

All HIV/AIDS case data presented in this profile are based on HIV and AIDS cases reported to the STD/AIDS Program through December, 1999, among persons who were residents of Idaho at the time of report. National rates, census information, and other survey information used are from the most recent available data. Some totals may not add to 100 percent due to rounding.

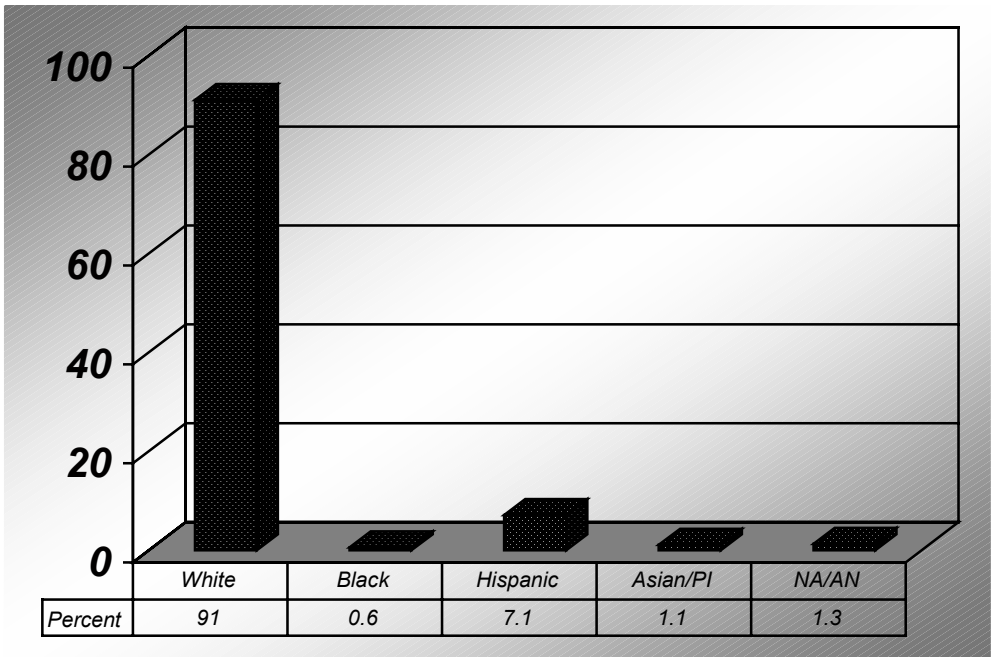
Policies established for confidentiality of an individual's identity are strictly enforced. Due to the relatively small number of HIV/AIDS cases, some cross-tabulations have not been performed in order to prevent the inadvertent disclosure of an individual's identity. For some calculations, groups with small numbers have been combined.

Question 1: What are the sociodemographic characteristics of the population?

The population of Idaho is estimated to be 1,228,684 in July of 1998. This data was released by the U.S. Bureau of the Census on September 15, 1999. The population was comprised of 91 percent white/non-Hispanic, 0.6 percent Black, 7.1 percent Hispanic, 1.1 percent Asian/Pacific Islanders, and 1.3 percent American Indian/Alaska Native.

Figure 1
Population by Race, 1998

Total Population = 1,228,684



Idaho had a land area of 82,751 square miles, ranks 11th in size, and 40th in population. Idaho is ranked 44th out of the 50 states with a population density of 14.6 persons per square mile. The population of Idaho is distributed unevenly across the state. Idaho has eight urban counties, twenty rural counties, and sixteen frontier counties (less than six persons per square mile).

U.S. Census data from 1998 shows that 12.5 percent or 153,585 people live below the federal poverty level. Some people (17.7 percent or 217,477) are estimated to be without insurance coverage, including Medicaid.

Planning Regions

Idaho is divided into seven prevention planning regions called Regional Prevention Councils (RPC) that correspond to the seven public health districts. There is also a statewide Prevention Planning Group (IPPG) that meets four times a year. Table 1 shows the population estimates for each district from July 1, 1998.

Table 1
Planning Group Region Populations

Residence	Total	White	Black	Am Indian/ Alaska native	Asian/ Pacific Islander	Hispanic*
District 1	169,405	165,931	389	2,271	814	3,881
District 2	97,286	92,899	421	2,712	1,254	1,815
District 3	179,853	174,935	664	1,949	2,305	28,446
District 4	313,979	303,337	3,050	2,261	5,331	13,764
District 5	157,257	154,064	619	1,213	1,361	18,281
District 6	157,150	149,108	1,206	5,297	1,539	12,467
District 7	153,754	150,536	809	962	1,447	9,627

*Included in appropriate race totals.
Source: U.S. Bureau of the Census, Internet release September 15, 1999.

Question 2: What is the impact of HIV/AIDS on the population?

As of December 31, 1999, 1,001 cases of HIV/AIDS had been reported to the Idaho Department of Health and Welfare STD/AIDS Program. Of these 1,001 cases, 479 have been diagnosed with AIDS while living in Idaho.

Case Rates In Planning Regions

The distribution of HIV cases among Idaho planning regions is illustrated in Figure 2 and AIDS cases are illustrated in Figure 3. Not surprisingly, the greatest numbers of cases are in District 4, 44 percent AIDS and 45 percent HIV. District 4 has the largest population of all the districts representing 25.5 percent of the total population in Idaho. The incidence of HIV and AIDS for each district is shown in Table 2.

Table 2
HIV/AIDS Incidence by District
Percent of Total Cases Since 1985

Diagnosis	District 1	District 2	District 3	District 4	District 5	District 6	District 7
AIDS	15%	3%	11%	44%	9%	11%	7%
HIV	10%	7%	12%	45%	10%	9%	7%

Figure 2
HIV by District through December 31, 1999

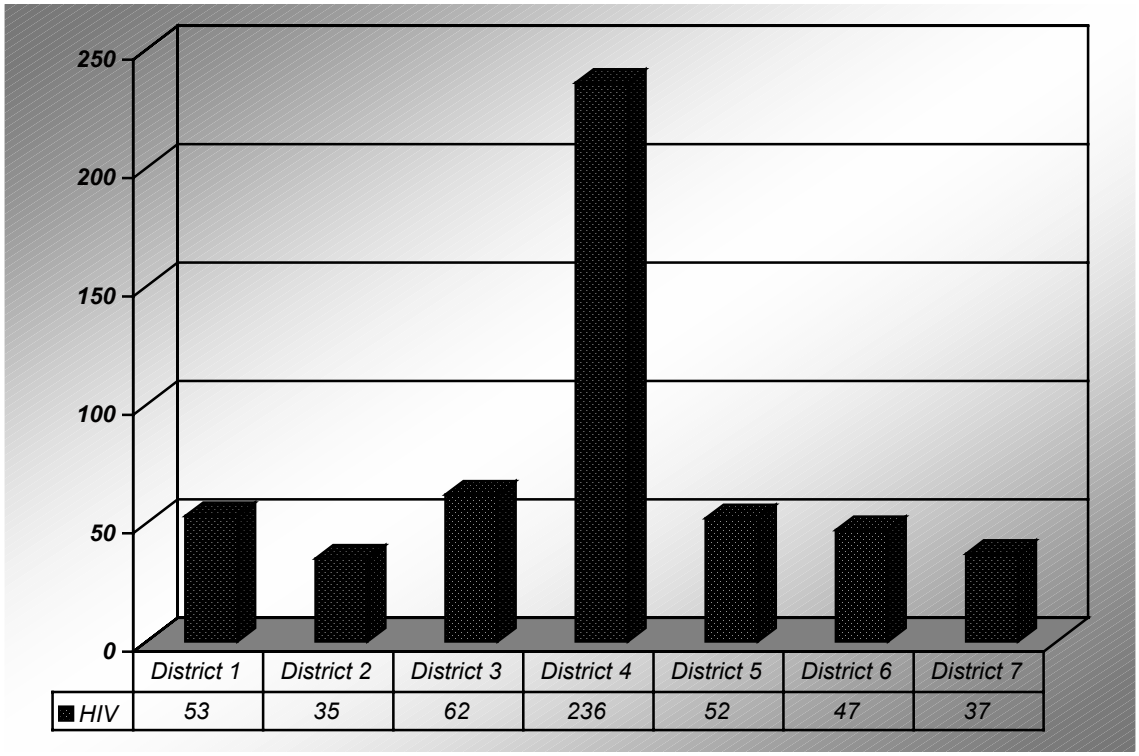


Figure 3
AIDS by District Through December 31, 1999

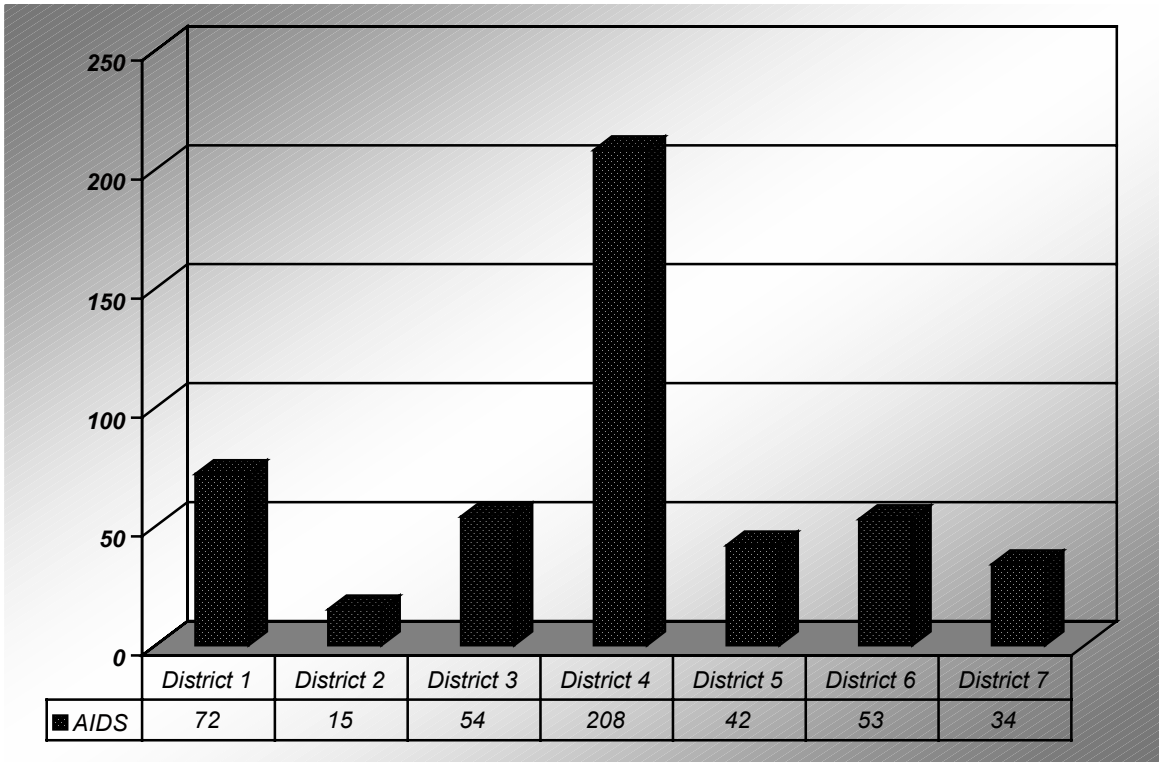


Figure 4 shows the prevalence of HIV in each planning region. This data is adjusted only for reported deaths. There is no adjustment for cases who may have moved out of state and no attempt is made to adjust for unreported cases.

Figure 4
Distribution of Living HIV Cases by Planning Region 1985- 1999

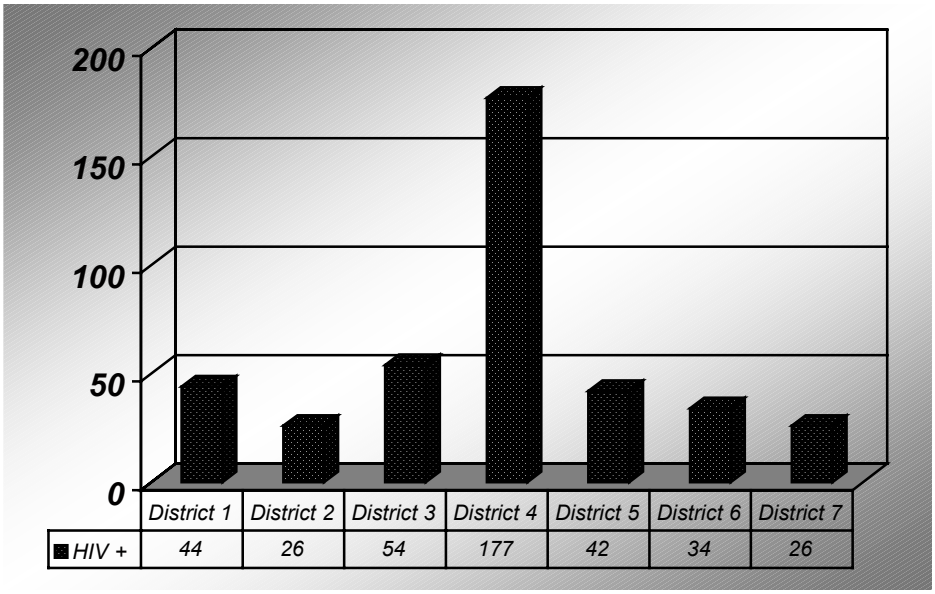
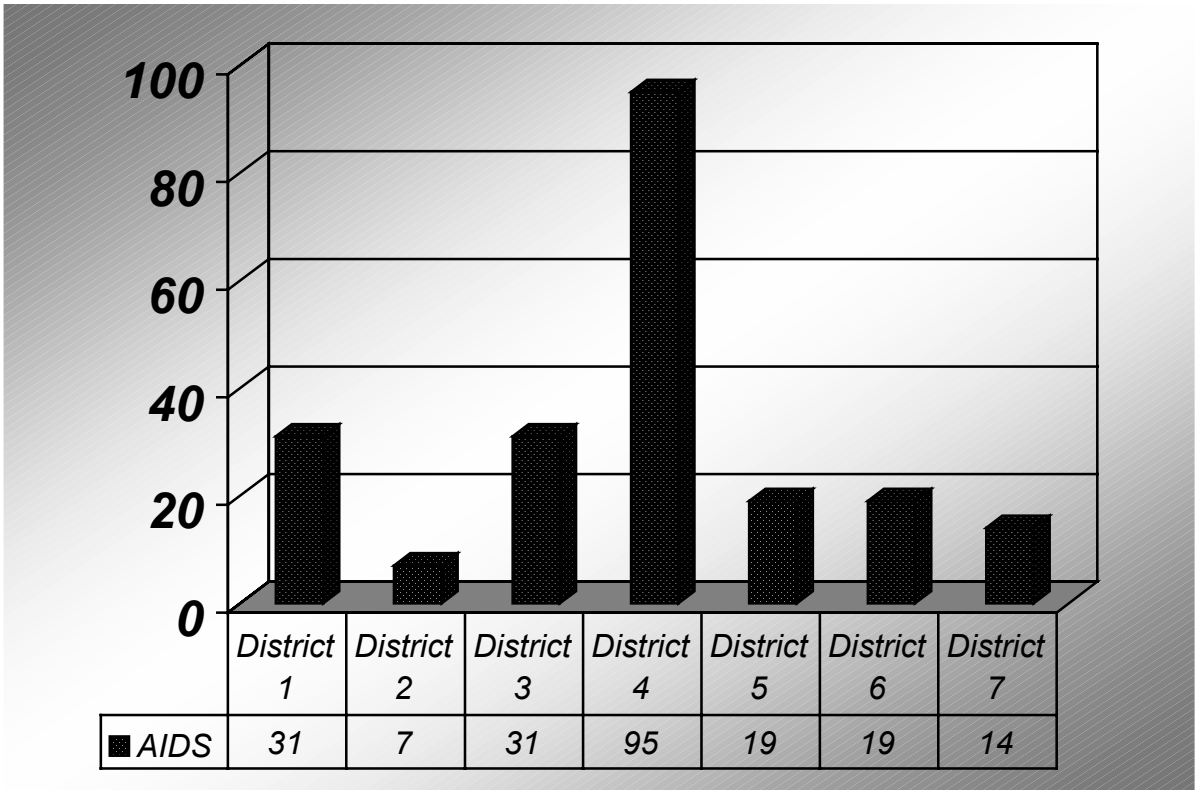


Figure 5 shows living AIDS cases reported in each planning district.

Figure 5
AIDS Prevalence by Planning Region 1985 - 1999



In 1999, there were 44 reported cases of HIV and 18 reported cases of AIDS. The overall rate of HIV infection is 3.6 cases per 100,000 population and 1.5 cases of AIDS per 100,000 population. Table 3 shows the cases reported by district.

Table 3
New HIV/AIDS Cases by District 1999
(Living)

Diagnosis	District 1	District 2	District 3	District 4	District 5	District 6	District 7	Total
AIDS	3	0	1	8	0	3	3	**18**
HIV	7	2	7	17	10	0	1	**44**

Epidemic Curve

The epidemic curves of HIV and AIDS in Idaho are shown in Figures 6 and 7. These figures are presented by year of the first positive HIV report in Idaho and the year of AIDS diagnosis in Idaho.

Figure 6
AIDS Cases by Year of Report 1985-1999
Incidence

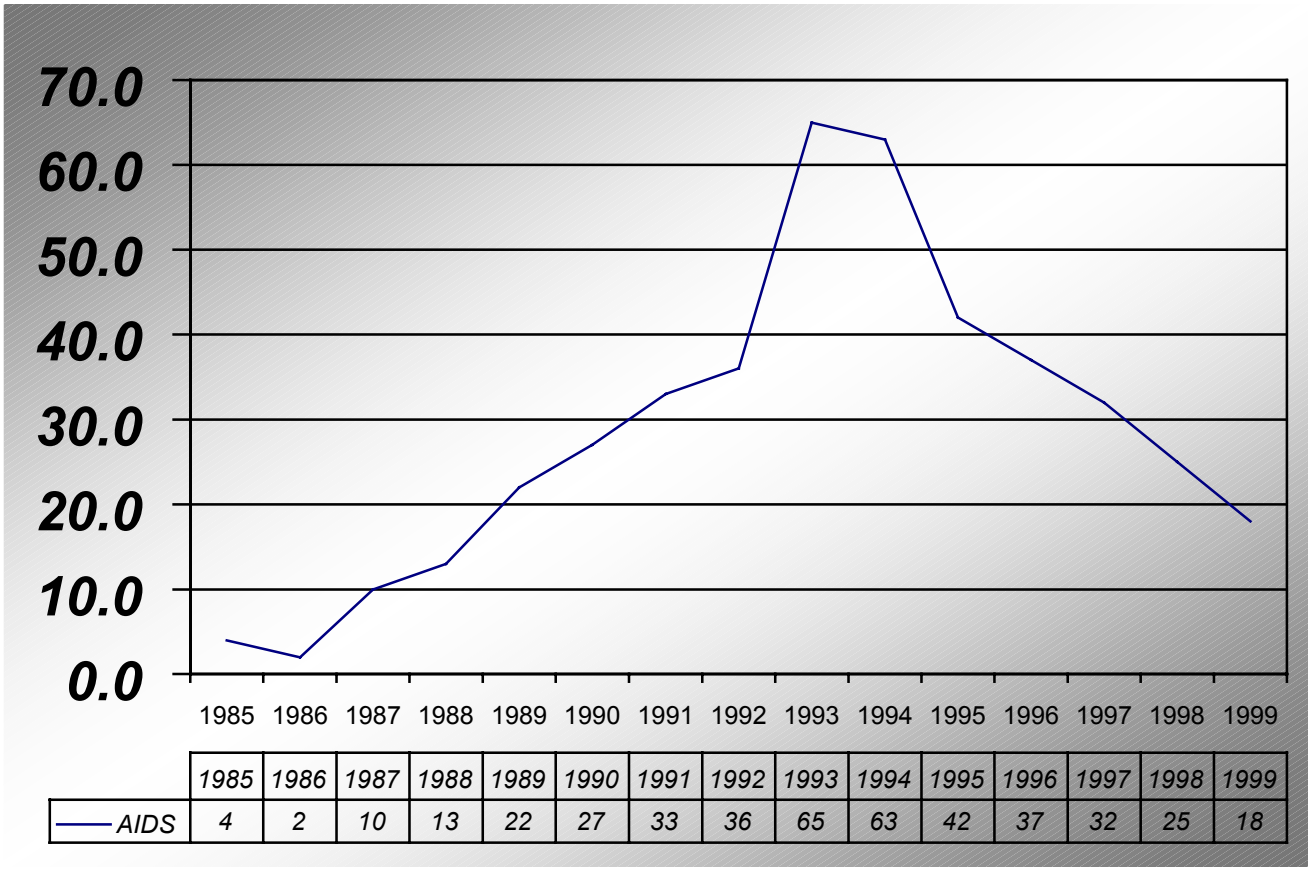
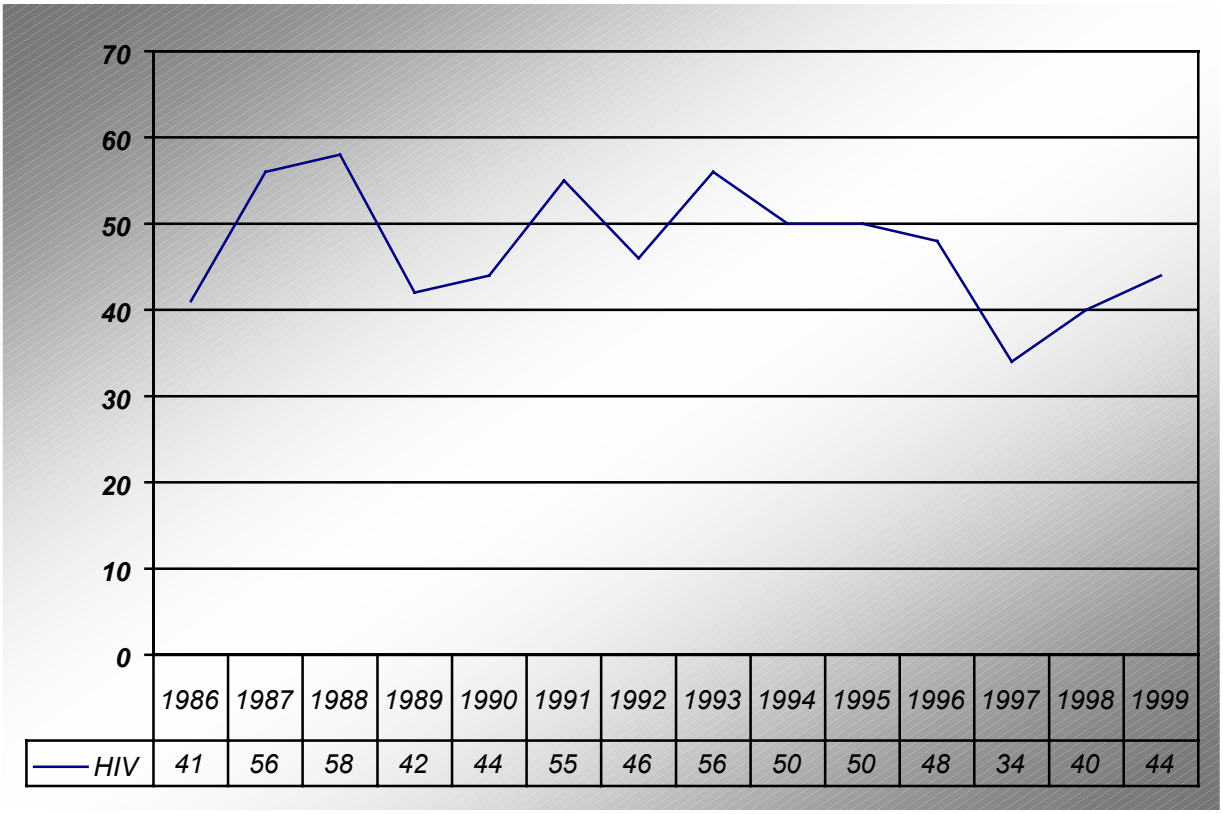


Figure 7
HIV by Year of Report 1986-1999
Incidence

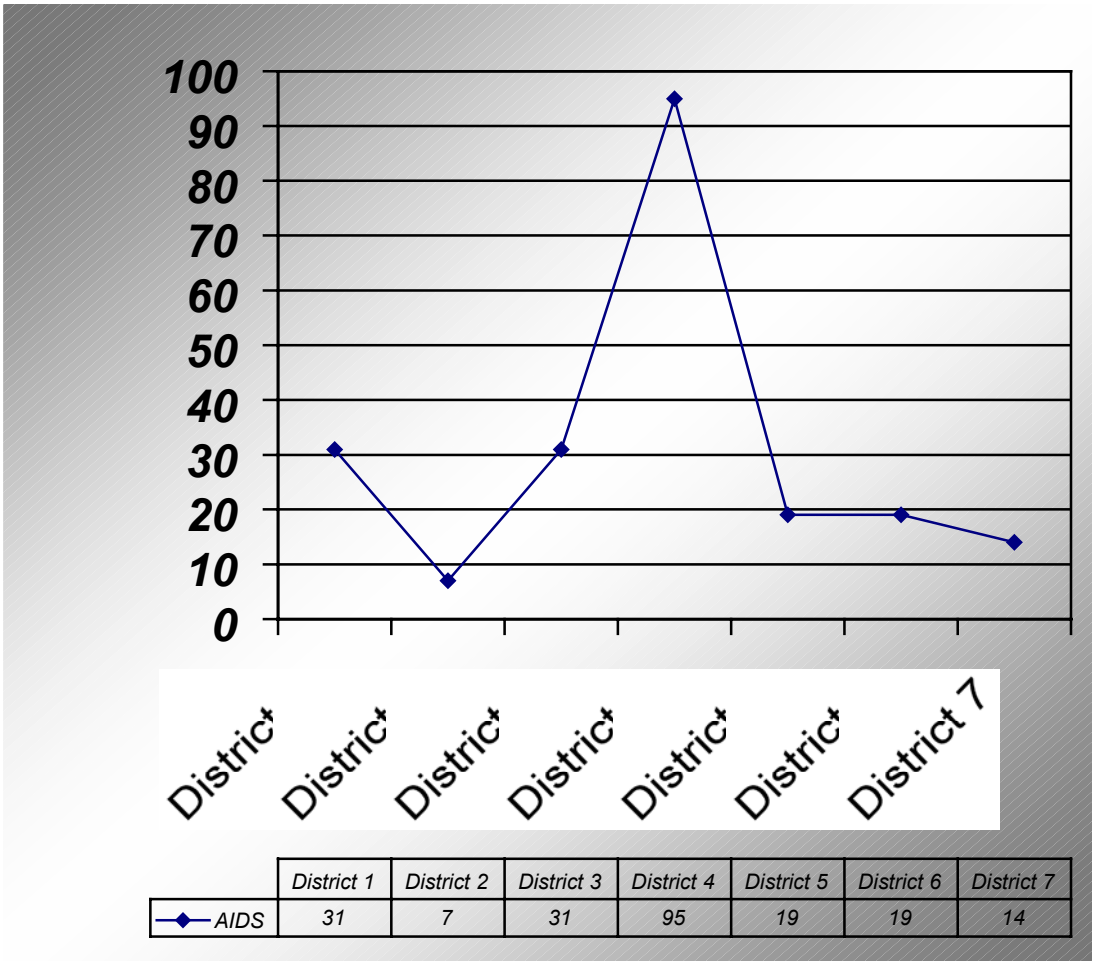


The increase in reported AIDS cases in 1993 and 1994 follows the expanded case definition for AIDS. The declining number of newly-reported cases starting in 1996 may be directly correlated to the availability of HAART (Highly Active Anti-retroviral Therapy). The declining number of HIV/AIDS related deaths are also attributed to the expanded availability of treatment in the United States. This trend is also documented nationwide.

The rate of newly reported HIV infections is remaining steady over the past several years. This trend is also reflected on the national level. Idaho is not documenting as rapid an increase in infected women of color and adolescents that is occurring in many other states.

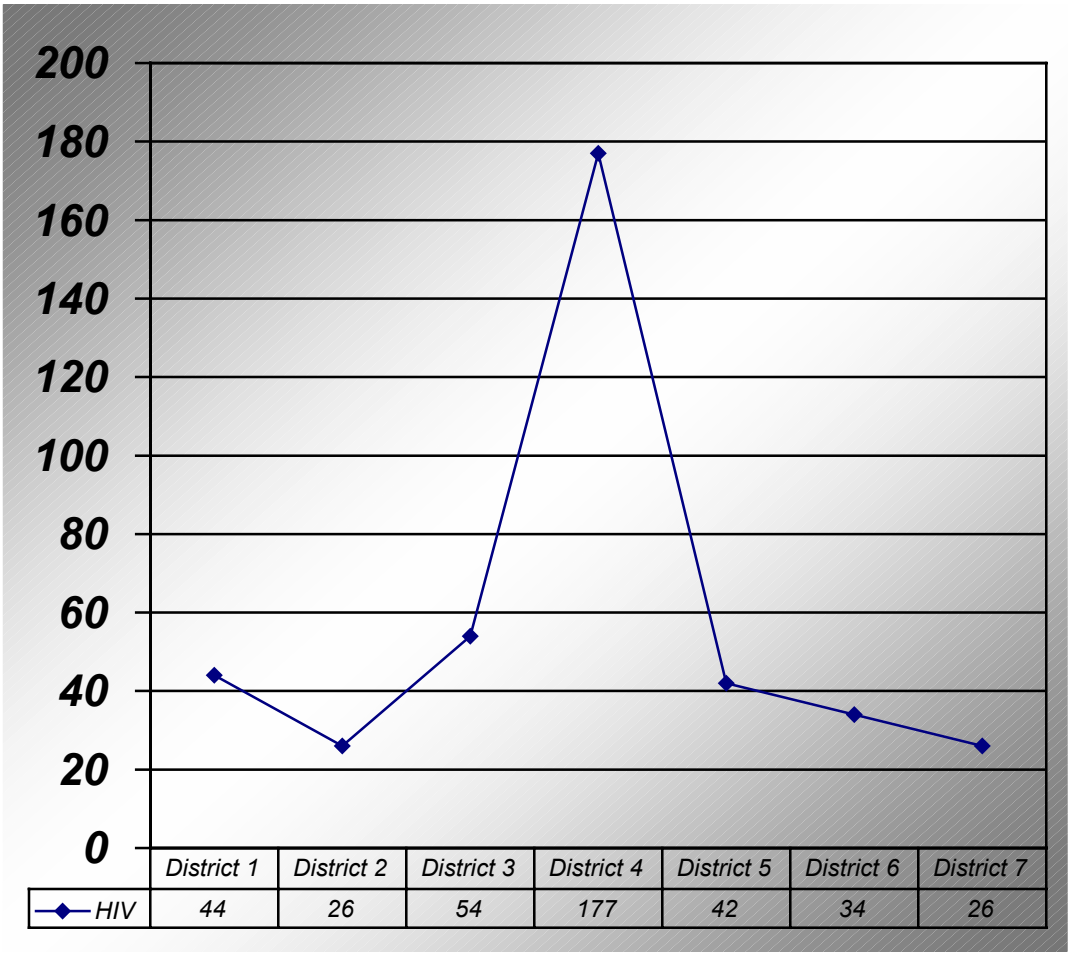
The following graphs are epidemiologic curves of HIV and AIDS prevalence (living cases) by planning district since 1985. This will be more reliable data on the potential number of cases in each area as well as documentation regarding the deaths that have occurred over time. There is no accurate method of determining how many cases still live in the area from which they were reported.

Figure 8
AIDS Prevalence by District, 1985-1999



	District 1	District 2	District 3	District 4	District 5	District 6	District 7
AIDS	31	7	31	95	19	19	14

Figure 9
HIV Prevalence by District 1985-1999



Distribution of Cases by Age, Gender and Race

There has been a total of 1,001 cases of HIV/AIDS reported in Idaho. Males are disproportionately represented in all seven district regions. Females comprise 140 (14 percent) and 861 (86 percent) are male. No one has identified as transgender. Twelve cases (1 percent) have been in children less than 13 years old. None of these children who were perinatally infected were born in Idaho. Eleven of the 13 cases were reported as being born to an HIV-positive or at-risk mother, with the remaining two cases reporting a risk factor of receipt of blood, components, or tissue.

Nationwide, 80 percent of the reported cases have been male, and 99 percent are cases older than 13 years of age at the time of testing positive. Table 4 provides a breakdown of age at time of testing in Idaho (this may reflect people tested previously in other states at earlier age), while Table 5 shows age at time of report for Idaho AIDS cases.

Table 4
Age at Time of HIV Testing in Idaho

AGE	ALL CASES	PERCENT
Under 5	8	2%
5-12	2	<1%
13-19	12	2%
20-24	80	15%
25-29	113	21%
30-39	213	41%
40-49	69	13%
50-59	18	3%
Over 59	4	<1%
Unknown	6	1%

Table 5
Idaho AIDS Cases by Age at Time of Report/Test

AGE	ALL CASES	PERCENT
Under 5	1	<1%
5-12	1	<1%
13-19	2	<1%
20-29	73	16%
30-39	215	46%
40-49	123	26%
Over 49	57	12%
Unknown	7	<1%

The 16 percent of AIDS cases reported in the 20-29 year old age group reflects people who may have been infected as adolescents. There were 193 reported HIV infections in this age group and many were probably infected in their teenage years. These statistics indicate that prevention activities need to begin early and continue into the third and fourth decade of peoples' lives.

Table 6 shows the race/ethnicity of the HIV/AIDS cases reported in Idaho. Whites appear to be proportionately affected. Native Americans appear to be underreported; this is anecdotal information from people working with Idaho's tribes.

Table 6
Race/Ethnicity of Reported HIV/AIDS Cases 1986-1999

Race/Ethnicity	Idaho Population	Idaho AIDS	Idaho HIV	U.S. AIDS (1998)
White	1,190,810	417 88%	444 85%	304,094 44%
Black	7,158	7 2%	21 4%	251,408 37%
Hispanic	88,281	38 8%	43 8%	124,841 18%
Am. Indian Alaskan Native	16,665	2 1%	6 1%	1,940 <1%
Other/Unk.	14,501	11 1%	8 2%	5,917 <1%
Total	1,317,415	479	522	688,200

The racial/ethnic population in Idaho is 91 percent White, 0.6 percent Black, 7.1 percent Hispanic, 1.3 percent Native American/Alaskan Native and 1.1 percent Asian/Pacific Islander. At this time, Idaho statistics do not reflect a disproportionate number of HIV/AIDS cases in the Hispanic population. The rate of cases in the Black population is 3.4 percent higher than the general population but the small number of total cases do not attribute to any statistical significance.

Estimate of HIV Prevalence in Idaho

Although the preceding data may be used to describe the impact of the cases where individuals have tested positive for HIV, they do not characterize the HIV epidemic in terms of the overall number of persons currently infected with HIV. Estimating the number of HIV positive individuals in Idaho or any specific population is difficult. Often, numbers of infected individuals who are not tested remain unknown. There is an unknown number of people currently diagnosed with HIV who have not been reported to the State Surveillance system.

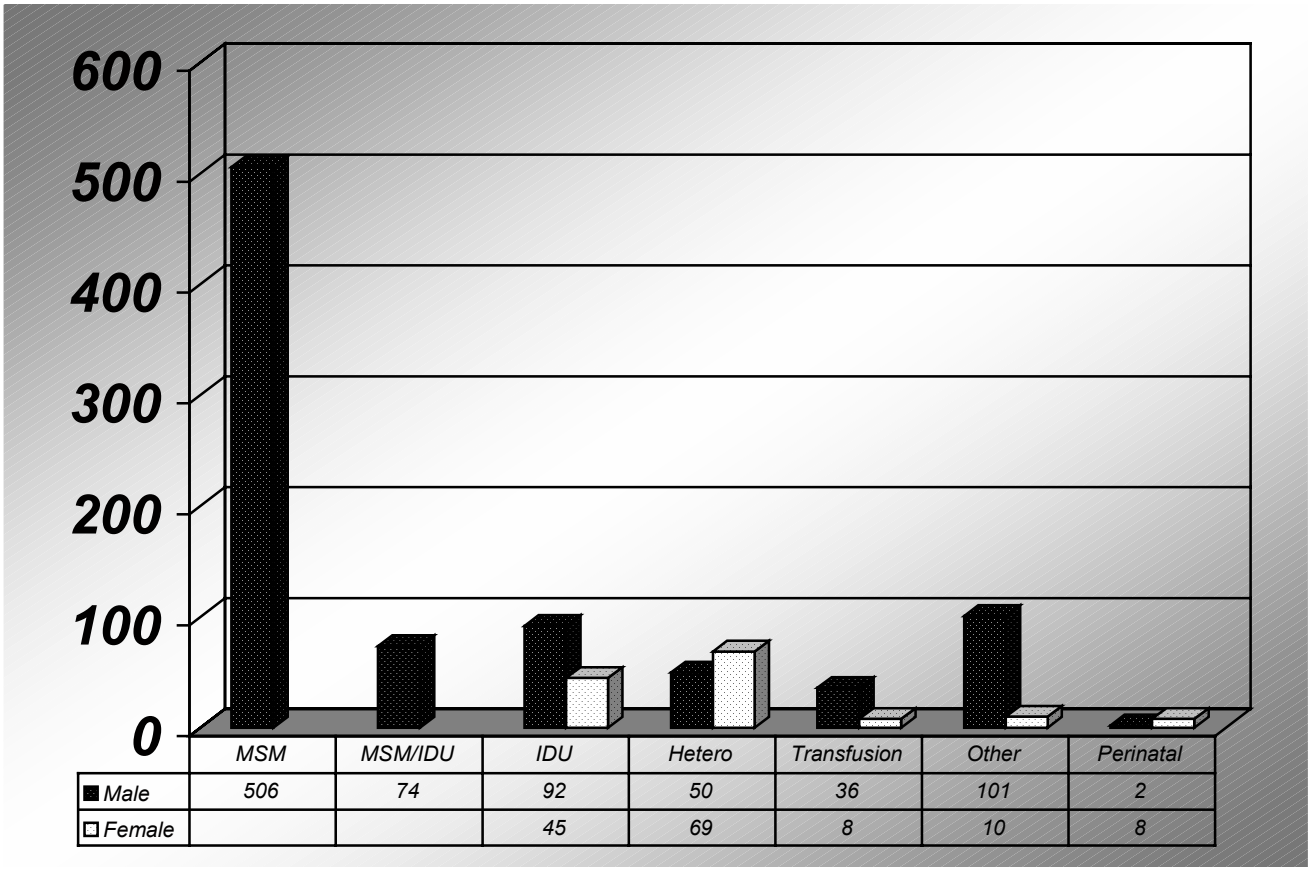
Question 3: Who is at risk of becoming infected with HIV?

The persons most likely to become infected with HIV are those who engage in high-risk behaviors in communities in which there is a high prevalence of HIV infection. Risk for HIV infection is determined by the frequency with which high-risk behavior is practiced, combined with the HIV prevalence in the community within which it is practiced.

Analysis of the characteristics of persons recently infected should help identify those persons at highest risk for becoming infected. However, because data on HIV incidence (new infections) is limited to those who are tested and reported, we must analyze data on persons currently infected and examine changes over time.

The data in this section will include all HIV positive people, both AIDS and HIV positive. Prevention strategies can be developed by examining the prevalence of the transmission routes in each planning district and monitoring trends and changes in each region. Figure 10 displays the risk factors for all reported cases since 1985.

Figure 10
HIV/AIDS Reported Risk Factors



	MSM	MSM/IDU	IDU	Hetero	Transfusion	Other	Perinatal
Male	506	74	92	50	36	101	2
Female			45	69	8	10	8

Statewide, males who have sex with males (MSM) is the predominate risk factor, 59 percent; followed by injection drug use (IDU), 11 percent; and MSM/IDU, 8.6 percent. Heterosexual

transmission accounts for 49 percent of the reported cases for females. An additional 32 percent of female cases are attributed to injection drug use.

Tables 7 and 8 show statewide data for the 5 year interval between 1995 and 1999 by race, risk factor, age and gender. Figure 11 graphs gender and risk factors statewide for 5 years.

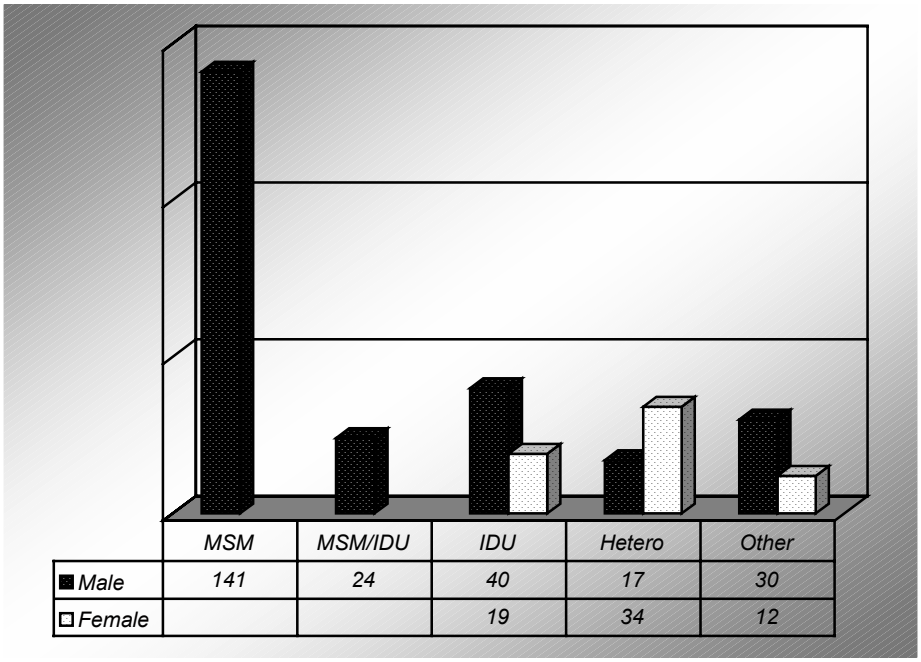
Table 7
Statewide Risk Factors by Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	119	22	46	40	33	**260**
Hispanic	15	2	8	7	3	**35**
Black	5		4	3	6	**18**
Native American	1		1			**2**
Asian	2					**2**
Total	**142**	**24**	**59**	**50**	**42**	**317**

Table 8
Statewide HIV/AIDS by Gender and Age
Prevalence 1995-1999

Gender	<15	15-20	21-30	31-40	41-50	>50	Total
Male	1	4	62	117	51	17	**252**
Female	5	4	25	19	12		**65**
Total	**6**	**8**	**87**	**136**	**63**	**17**	**317**

Figure 11
HIV/AIDS Risk Factors Statewide
Prevalence 1995-1999



	MSM	MSM/IDU	IDU	Hetero	Other
Male	141	24	40	17	30
Female			19	34	12

Data for the individual districts will reflect the last five years' prevalence. The mobility of the population makes it difficult to estimate how many people with HIV still live in their reported area. Limiting the data to a five-year interval will more accurately reflect the current trends and populations still residing in the reporting district. Figures 12-18 and Tables 9-23 will reflect age, race/ethnicity, and risk factors for each district.

Table 9
District 1 Risk Factors by Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	11	4	10	8	6	39
Hispanic				1		1
Black					2	2
Native American				1		1
Asian						
Total	11	4	10	10	8	43

Table 10
District 1 HIV/AIDS by Gender and Age
Prevalence 1995-1999

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male			5	8	11	2	26
Female	3	1	3	4	6		17
Total	3	1	8	12	17	2	43

Figure 12
HIV/AIDS Risk Factors District 1
Prevalence 1995 - 1999

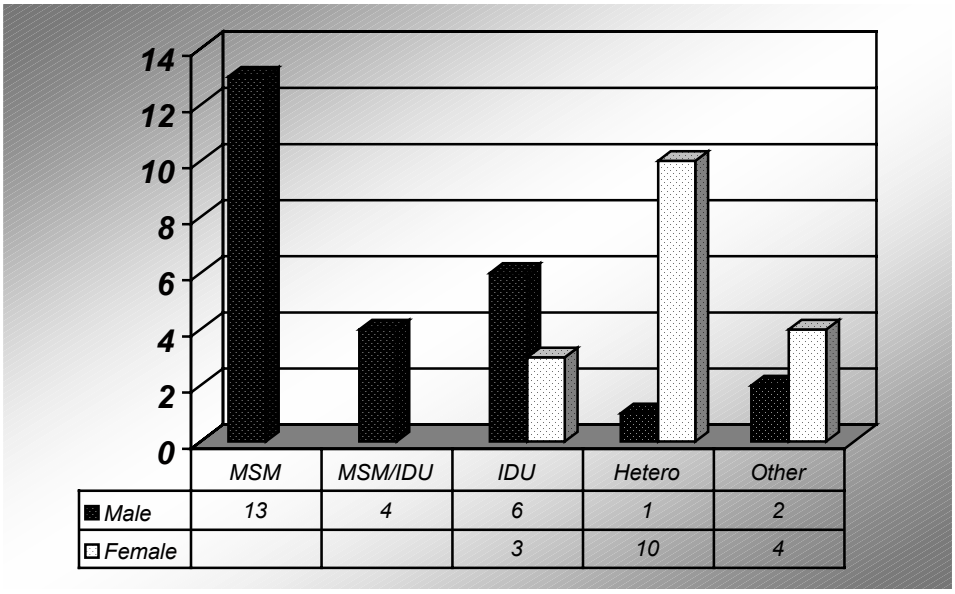


Table 11
District 2 HIV/AIDS by Risk Factors and Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	Hetero	Other	Total
White	2	3	3	1	4	13
Black						
Hispanic	1					1
Native American						
Asian						
Total	3	3	3	1	4	14

Table 12
District 2 HIV/AIDS by Age and Gender Distribution
Prevalence 1995-1999

GENDER	<15	16-20	21-30	31-40	41-50	>50	Total
Male			2	8			10
Female			2	2			4
Total			4	10			14

Figure 13
HIV/AIDS Risk Factors District 2
Prevalence 1995-1999

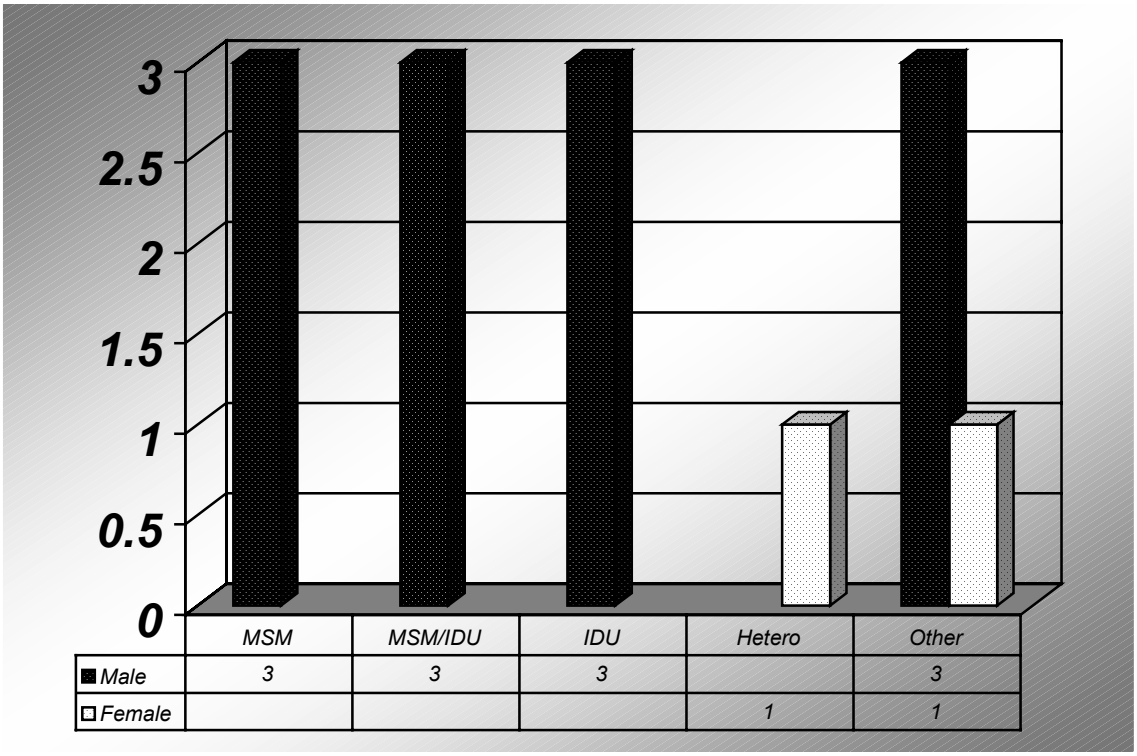


Table 13
District 3 HIV/AIDS by Risk Factor and Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	14	1	7	3	6	31
Hispanic	4	1		3	2	10
Black						
Native American			1			1
Asian						
Total	18	2	8	6	8	42

Table 14
District 3 HIV/AIDS by Age and Gender Distribution
Prevalence 1995-1999

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male			8	17	6	2	33
Female		2	5	1	1		9
Total		2	13	18	7	2	42

Figure 14
HIV/AIDS Risk Factors District 3
Prevalence 1995-1999

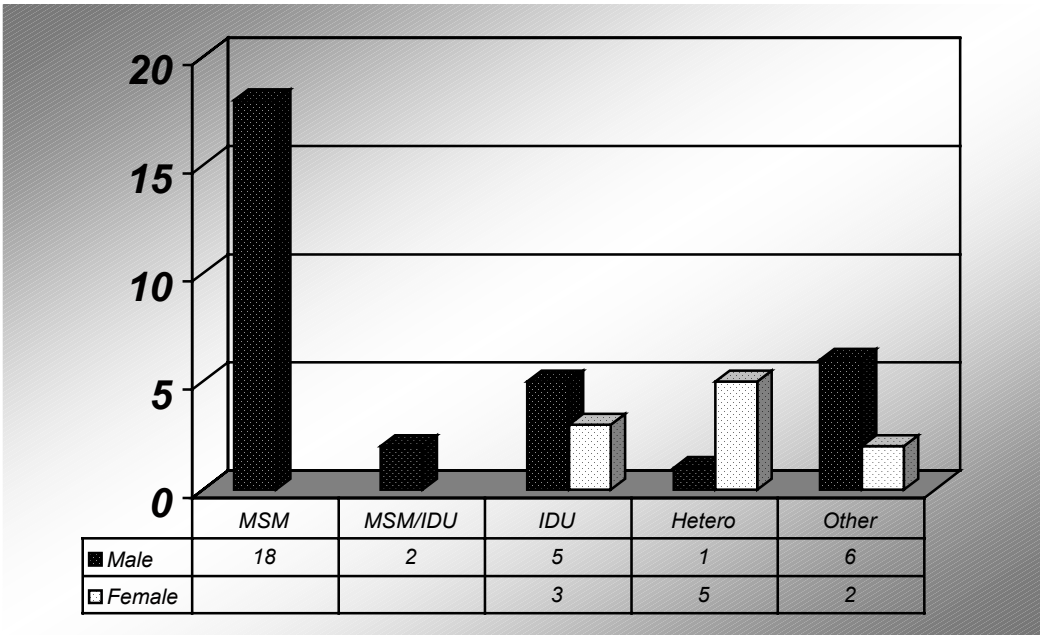


Table 15
District 4 HIV/AIDS by Risk Factor and Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	61	11	18	10	11	111
Hispanic	7		4	1		12
Black	4		3	1	1	9
Native American						
Asian	2					2
Total	74	11	25	12	12	134

Table 16
District 4 HIV/AIDS Age and Gender Distribution
Prevalence 1995-1999

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male			26	55	24	10	115
Female	1		7	8	3		19
Total	1		33	63	27	10	134

Figure 15
HIV/AIDS Risk Factors District 4
Prevalence 1995-1999

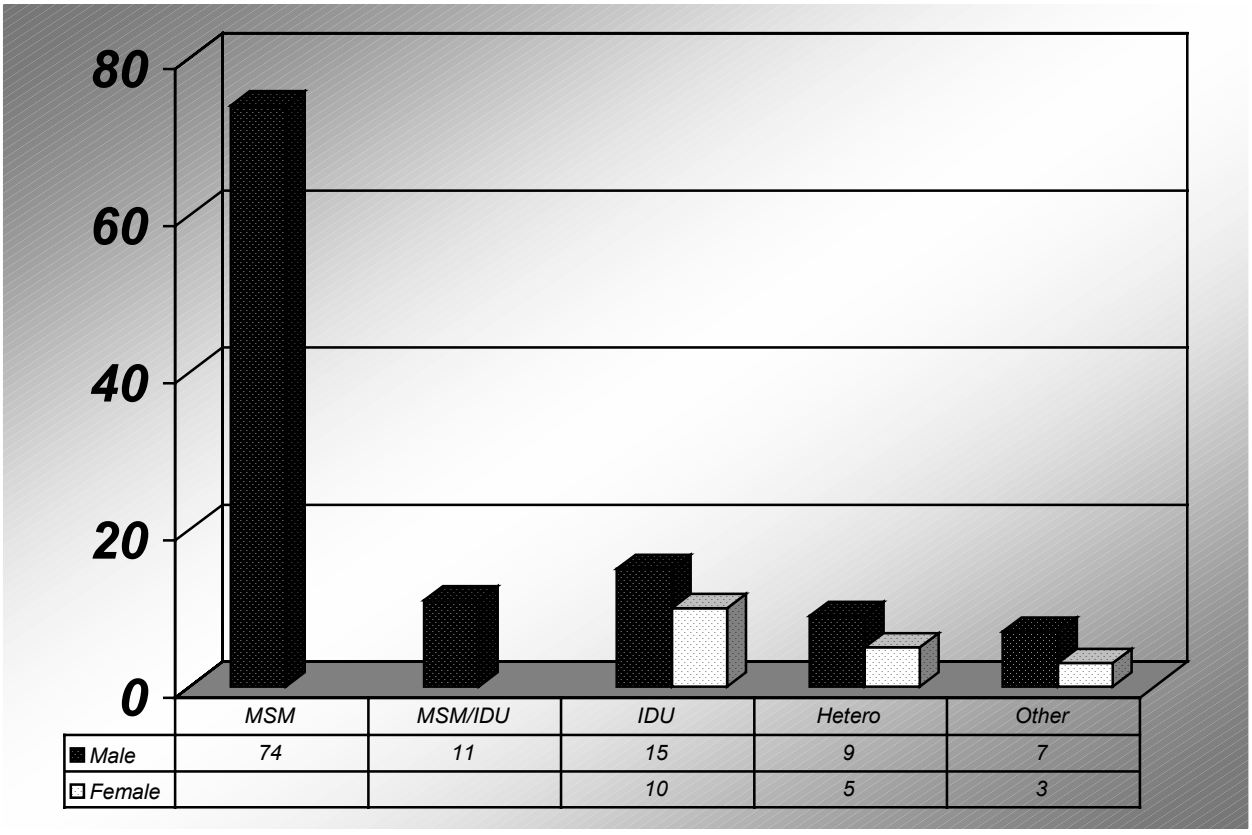


Table 17
District 5 HIV/AIDS by Risk Factor and Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	10	1	2	9	2	24
Hispanic	1		2		1	4
Black	1					1
Native American	1					1
Asian						
Total	13	1	4	9	3	30

Table 18
District 5 HIV/AIDS Age and Gender Distribution

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male	1	2	5	8	6	1	23
Female		1	4	1	1		7
Total	1	3	9	9	7	1	30

Figure 16
HIV/AIDS Risk Factors District 5
Prevalence 1995 - 1999

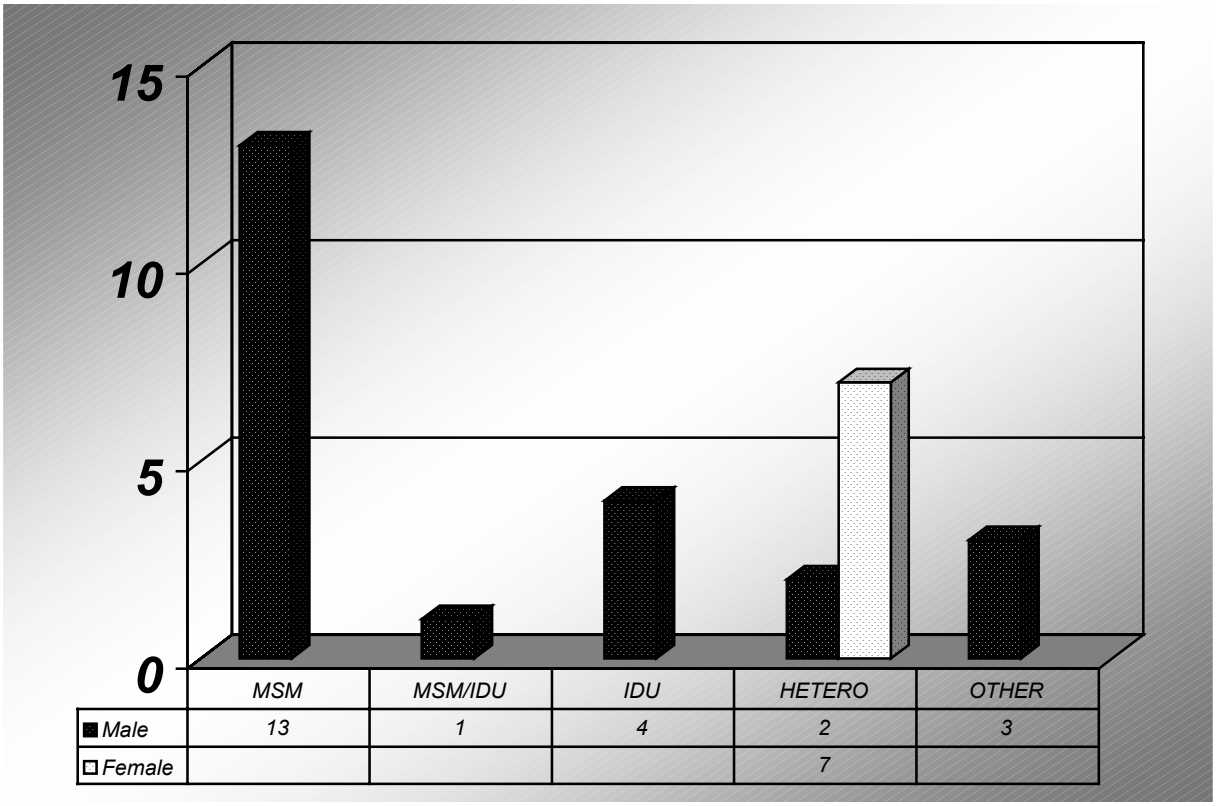


Table 19
District 6 HIV/AIDS by Risk Factor and Race/Ethnicity
Prevalence 1995-1999

RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	12	1	3	7	1	23
Hispanic		1	1	2		4
Black			1	1	2	4
Native American						
Asian						
Total	12	2	5	10	3	32

Table 20
District 6 HIV/AIDS Age and Gender Distribution
Prevalence 1995-1999

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male		1	8	9	2	3	23
Female	1		3	4	1		9
Total	1	1	11	13	3	3	32

Figure 17
HIV/AIDS Risk Factors District 6
Prevalence 1995 - 1999

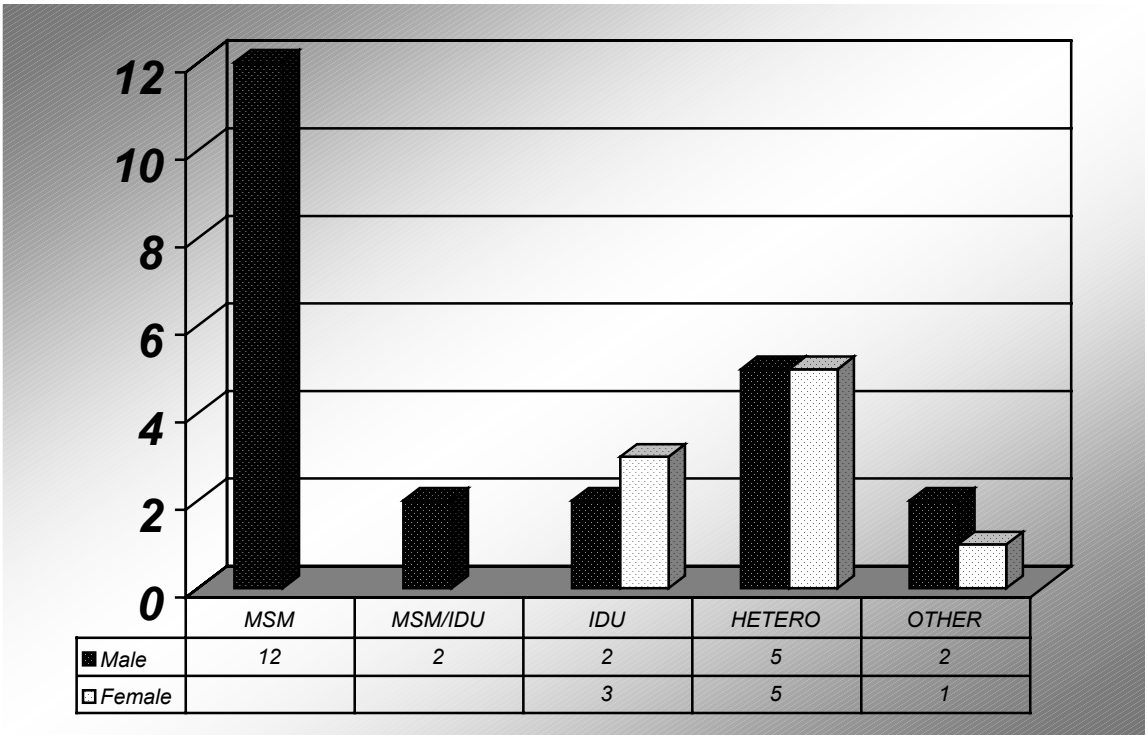


Table 21
District 7 HIV/AIDS by Risk Factor and Race/Ethnicity
Prevalence 1995-1999

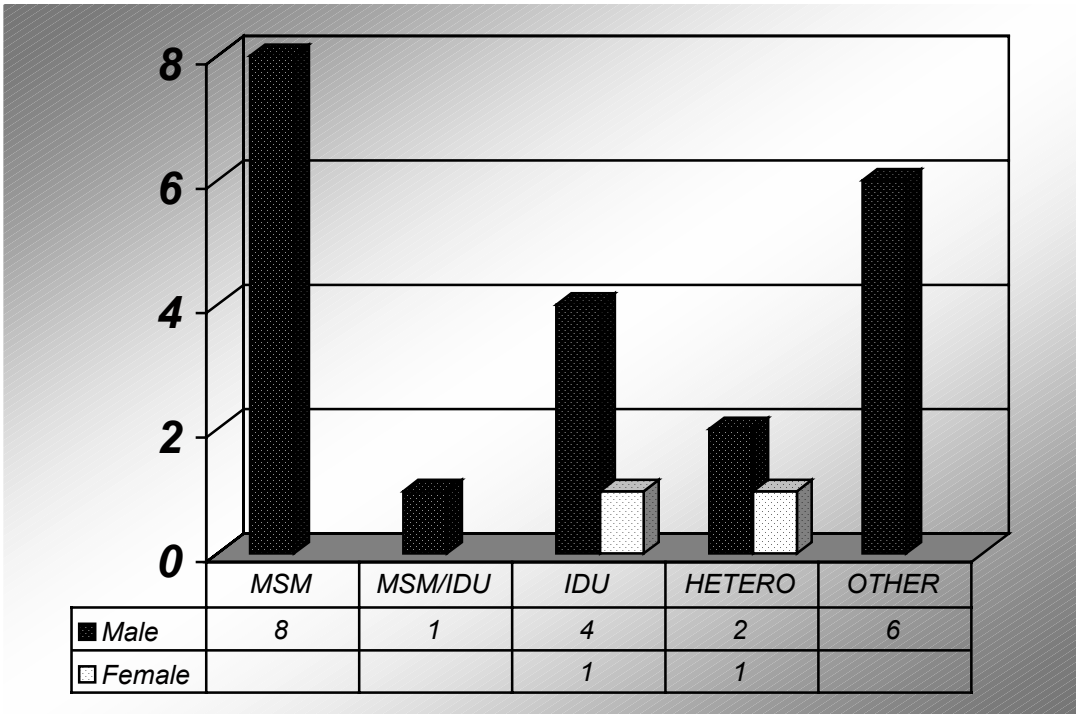
RACE	MSM	MSM/IDU	IDU	HETERO	OTHER	Total
White	7	1	4	1	5	18
Hispanic	2		1			3
Black				1	1	2
Native American						
Asian						
Total	9	1	5	2	6	23

Table 22
District 7 HIV/AIDS Age and Gender Distribution
Prevalence 1995-1999

GENDER	<15	15-20	21-30	31-40	41-50	>50	Total
Male		1	6	10	2	1	20
Female			2				2
Total		1	8	10	2	1	22

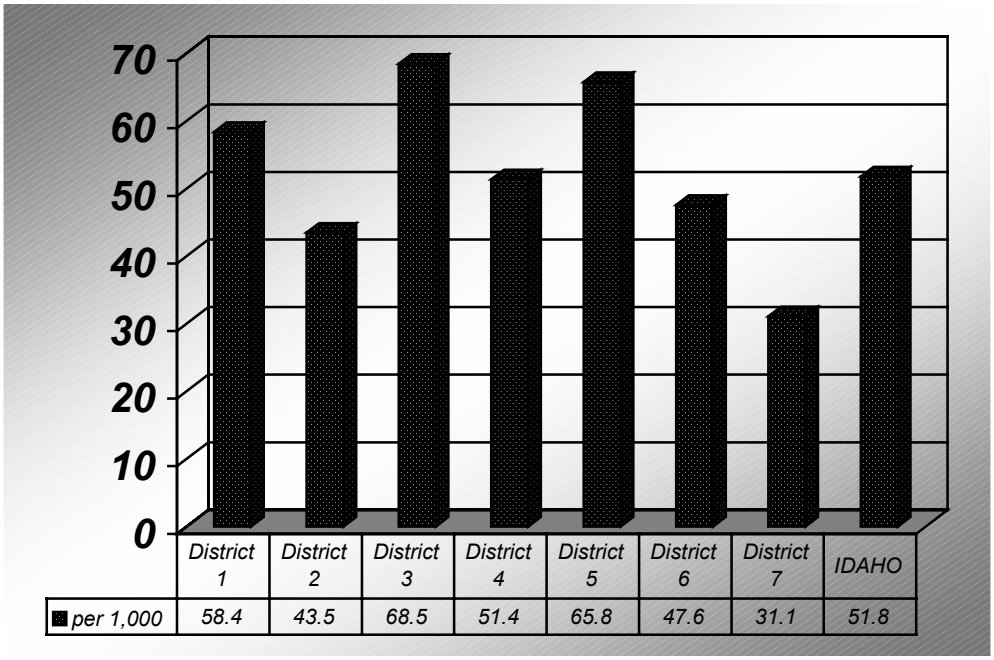
*one male's age unknown

Figure 18
HIV/AIDS Risk Factors District 7
Prevalence 1995 - 1999



HIV/AIDS Behavioral Risk Factors. Teen pregnancy rates are one way to measure unprotected sex as a risk factor. In 1998, 28 girls under the age of 15 delivered a live infant. There were 2,450 live births reported to females 15-19 years of age. Figure 18 shows teen pregnancy rates in 15-19 year olds by district for 1998.

Figure 19
Teen Pregnancy Rates by District, 15-19 year olds



Another measure of unprotected sex is the number of reported Chlamydia cases and Gonorrhea cases. In 1998 there were a total of 181 cases of gonorrhea and 2,019 cases of Chlamydia in Idaho. Of these combined cases, 930 STDs were reported in youth under 19.

Idaho has not been able to conduct a complete Youth Risk Behavior Survey (YRBS) for the past three years. This survey would provide indicators of youth sexual activity and drug use. Participating school districts are selected through a random sample process with district-level approval required. Many school districts have chosen not to participate in this voluntary survey due to the inclusion of sexual behavior questions.

Alcohol and Drug Use. People who abuse alcohol and drugs may be more likely to participate in high-risk behavior. Sharing needles between injection drug users has been proven to be a high-risk activity for transmission of HIV. The Bureau of Mental Health and Substance Abuse (BMHSA) annually collects data on people who seek treatment for drug and alcohol abuse. The information is gathered from all programs, inpatient and outpatient, that receive state funds.

The average number of adult clients admitted for treatment per year since 7/1/97 is 4,875. Eighty six percent are white, 9 percent are Hispanic, 2 percent are Native American and less than 1

percent Black or Asian. The primary drug of abuse is alcohol followed by methamphetamines and marijauna. Injection, as the route of administration, was identified by an average of 13 percent of the clients for the past four years.

The average number of adolescent clients admitted for treatment per year since 7/97 is 1,332. Twenty percent are 10-14 years of age, and 79 percent are between 15-17 years of age. The primary drug of abuse is marijuana, followed by alcohol and then methamphetamines. Eighty five percent of the adolescents served by BMHSA are white, 12 percent Hispanic, 2 percent Native American, and less than 1 percent Black or Asian. Between 3 percent and 6 percent of the adolescents say they have used injection drugs.

HIV testing is offered to all the inpatient clients and the majority of the outpatient clients according to the Substance Abuse Program. An average of 20 percent of the adolescents say they were tested and 54 percent of the adults received tests while in treatment. The need to increase the number of people, especially adolescents, who are tested is apparent. There is no available data on the percentage of positive tests.

The highest risk group is the injection drug users. Methamphetamines are known to increase sexual urges in a percentage of the population and can impair judgement. Alcohol is cited anecdotally by many clients as the reason they engage in unsafe sex. Heroin users typically report a reduced desire and ability to perform sexually so unless they share needles they are lower risk than other substance users.

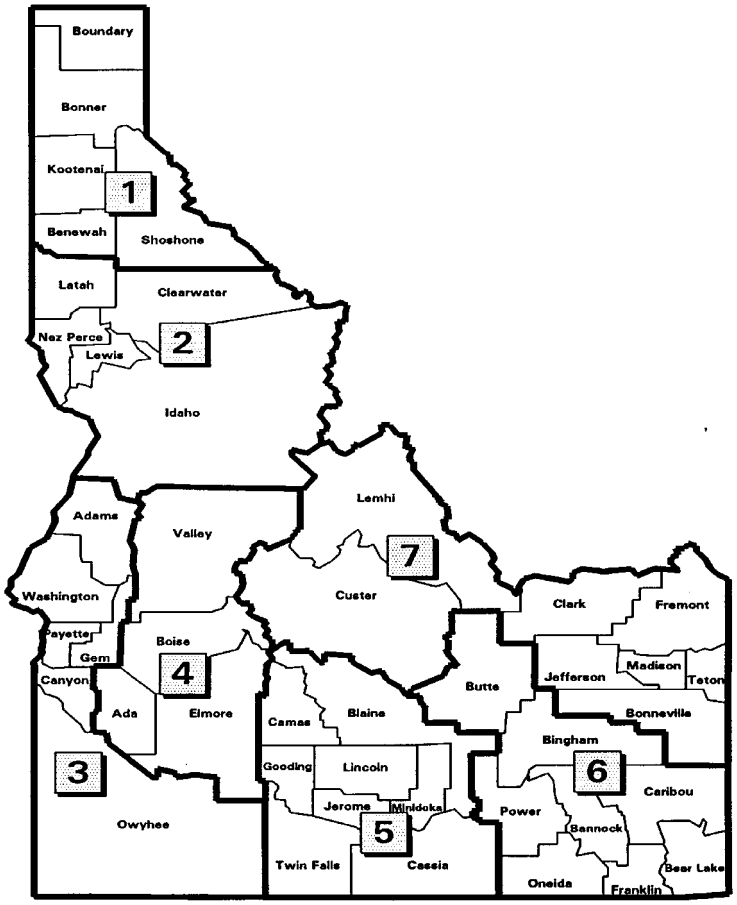
Perceived Risks and Adult Beliefs about HIV/AIDS. Idaho Department of Health and Welfare, Center for Vital Statistics and Health Policy conducted a survey of adults 18-64 in 1998. Questions addressed knowledge, attitudes and beliefs about HIV/AIDS. Eighty-three to 90 percent of the 3,753 people surveyed believed HIV education should start in elementary school. Eighty-two to 93 percent of respondents would encourage their teen-agers to use condoms if they were sexually active.

Three percent of survey respondents considered themselves at high risk for HIV. Four percent of respondents perceived themselves to be at medium risk. The survey also asked who had been tested for HIV. The majority of the respondents who had tested received the test as part of routine health care. Four hundred and fifty-two people stated they had tested in the 12 months preceding the survey. Fourteen people (3 percent) tested because they felt they were at risk. The majority of the people tested at their private providers office. Age and gender had little impact on who tested. Older adults are less likely to test than middle age or young adults.

Summary of Who is at Risk in Idaho. HIV/AIDS in Idaho is primarily found in white males who have sex with other males. Though the percentage of cases involving males who have sex with males is decreasing slightly, this is still the most common risk factor. The risk category of injection drug use is increasing for both men and women. Heterosexual transmission, as the only identified risk, is also increasing for both males and females.

Question 4: What is the geographic distribution of HIV infection?

Thirty-nine of Idaho's 44 counties have reported at least one case of HIV or AIDS. To protect an individual's confidentiality we do not report HIV cases by county as many counties are minimally populated and have very few cases reported. The counties with no reported cases include Camas, Caribou, Fremont, Lewis, and Lincoln. The greatest numbers of cases are from Ada County. The counties with the fewest reported cases per 100,000 population are Twin Falls, Bannock, and Kootenai.



NEEDS ASSESSMENT

The Idaho HIV Prevention Planning Group (IPPG) conducts a needs assessment of one priority population each year. In Fall 1999 – Spring 2000, the IPPG focused on men who have sex with men (MSMs). The purpose of the needs assessment was to identify attitudes and behaviors of Idaho MSMs and support statewide efforts to plan HIV prevention activities for a risk population living in a low population density state.

The assessment involved two stages: 1) a series of semi-structured MSM focus group discussions, and 2) an anonymous survey of MSMs. Results of the needs assessment are described below.

Focus groups. Three MSM focus groups were conducted by HIV Prevention Advocates, one in north Idaho, one in eastern Idaho, and one in southeastern Idaho. Common themes in the discussions resulted in these findings:

- Gay men are "AIDS-ed" out and weary with HIV prevention messages.
- Men perceived condoms as a barrier to intimacy.
- Rural MSMs wished for more opportunities to safely gather and socialize.
- MSMs valued relationships and monogamy.
- MSMs faced overt discrimination in jobs, housing, health care, and church membership, and many have experienced violence.
- Gay youth experienced lack of support from school officials and their communities. Many participants knew of gay youth who were suicidal.
- Rural gay men travel to larger cities outside of Idaho for sex.

The focus group participants also made these recommendations:

- HIV prevention must be done in the larger context of gay men's lives.
- Reach younger MSMs via the internet.
- Identify and support local gay leaders, organize local gatherings and fun events.
- Establish local Rural Gay Men's Advisory Councils on gay men's health issues.
- Identify and involve local religious leaders and organizations.
- Further uncover in the community what motivates risk reduction.

Survey. The statewide MSM survey was designed and piloted by the IPPG's Needs Assessment and MSM Committees in collaboration with Dr. Peter Vik, a behavioral scientist from Idaho State University. The survey primarily addressed condom use and other risk behaviors. Participants were 75 MSMs; three-fourths of the respondents were white, compared to 97 percent of all Idaho male residents who are white.

The results indicate that 76 percent of the respondents engaged in at least one risky sexual activity without using a condom during the past six months; 27 percent admitted to three or

more unprotected sexual behaviors. Seventy six percent reported never using condoms, while only 15 percent claimed to always using condoms.

Respondents reported three primary reasons for not using condoms: 1) The partner did not wish to, 2) Using a condom would result in loss of pleasure, and 3) The respondent and partner had the same HIV status.

MSMs younger than age 21 were twice as likely as the other age groups to have sex without a condom, and reported more concern about their partner's reaction to use of a condom.

RESOURCE INVENTORY

Each of Idaho's seven health districts has one half-time HIV Prevention Advocate funded by the Idaho STD/AIDS Program. The Advocates work with Regional HIV Prevention Councils (RPCs) and other local organizations to plan, implement and evaluate regional HIV prevention interventions. Each RPC is also allocated $2,000 in state funding for its prevention work.

In addition, the Idaho STD/AIDS Program contracts with several community-based organizations to conduct prevention activities that reach priority populations. These include the North Idaho AIDS Coalition; the Sojourner's Alliance Stonewall Health Project in north central Idaho; the Idaho Migrant Council, Idaho AIDS Foundation, and Mountain States Group in southwest Idaho; and the NAACP in southeast Idaho. Each district health department also receives state funds to provide counseling, testing, referral and partner notification for persons at risk of HIV.

Prevention resources of each health district are outlined below.

District I

North Idaho AIDS Coalition: outreach, public education, group level interventions for MSMs and women at-risk.
Panhandle District Health Department: testing and counseling.
Spokane AIDS Network: outreach, public education, prevention case management, testing.

District II

Sojourner's Alliance: outreach, public education, and group level interventions for MSMs.
North Central District Health Department: public education, testing and counseling.
American Red Cross

District III

Southwest District Health Department: public education, testing and counseling.
Idaho Migrant Council: outreach, individual level interventions.

District IV

Central District Health Department: testing and counseling.
Idaho AIDS Foundation: community level education, group interventions with MSMs.
Mountain States Group: community level outreach and education, group level interventions with MSMs.
Planned Parenthood: testing and counseling.
Family Practice Residency: prevention case management.
American Red Cross

District V

South Central Idaho AIDS Coalition: public education.

South Central District Health Department: public education, counseling and testing.
American Red Cross

District VI

Southeast Idaho AIDS Coalition: community level education.
Southeast Idaho District Health Department: community education, outreach, counseling and testing.
NAACP: outreach, community education, group level interventions for women at-risk.
American Red Cross

District VII

District VII Health Department: community level education, counseling and testing.
American Red Cross

GAP ANALYSIS

After the MSM survey results were completed, a gap analysis of MSM prevention needs was conducted in Spring 2000. The purpose of the gap analysis was to determine how well existing programs were responding to MSM prevention needs. This was accomplished on a district-level basis. On completion of the gap analysis, the information was reviewed by the MSM Committee of the IPPG to make recommendations for prevention interventions.

The chart on the following page summarizes the results of the gap analysis. Districts 4 and 5 chose to analyze gaps for different age groups of MSMs.

In 2001, a gap analysis of the prevention needs of women with high risk partners will be conducted, and in 2002, the same will be done for injection drug users.

SUMMARY OF GAPS IN HIV PREVENTION SERVICES FOR MEN WHO HAVE SEX WITH MEN IN IDAHO

HIV Prevention Needs of MSM:	KNOWLEDGE about HIV transmission, risk behaviors, and serostatus	PERSUASION to behave in a new, healthy way	SOCIAL SUPPORT to reaffirm the value of a healthy behavior	COMMUNICATION SKILLS to enable the effective negotiation of safer behaviors	ACCESS to tools and services
District I	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need
District II	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need
District III	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need
District IV, age 21 and over	Unmet Need	Unmet Need	Met Need	Unmet Need	Unmet Need
District IV, under age 21	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need
District IV, age 18 and under	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need
District V, ages 16-25	Met Need	Unmet Need	Unmet Need	Unmet Need	Met Need
District V, age 18+	Met Need	Unmet Need	Unmet Need	Unmet Need	Met Need
District VI	Met Need	Unmet Need	Unmet Need	Unmet Need	Met Need
District VII	Unmet Need	Unmet Need	Unmet Need	Unmet Need	Unmet Need

POTENTIAL STRATEGIES AND INTERVENTIONS

The types of interventions listed below can potentially be used to reach any of Idaho's three priority populations: men who have sex with other men, injection drug users, and women at-risk.

Individual Level Intervention. Health Education/Risk Reduction counseling with a skills component, provided to one person at a time.

Group Level Intervention. Health Education/Risk Reduction counseling with a skills component provided to more than one person at a time, and involves more than one interaction.

Outreach. Educational interventions conducted face-to-face in places where the priority population congregates, for more than the purpose of counseling and testing.

Prevention Case Management. Client-centered Health Education/Risk Reduction counseling with a case management component.

Partner Counseling and Referral Services. A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV and gain access to counseling, testing, treatment and other prevention services.

Health Communications/Public Information. Use of electronic or print media, educational presentations or lectures, hotlines or clearinghouses to deliver planned prevention messages to support risk-reduction, provide information, increase awareness, or build support for safe behavior.

Other Community Level Interventions. These may include social marketing campaigns, community-wide events, policy interventions, or structural interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole.

PRIORITIZATION OF POPULATIONS AND INTERVENTIONS

Priority Populations. Based on the state's epidemiological profile, the IPPG has decided to continue prioritizing three populations with HIV prevention interventions:

- Men who have sex with other men (MSMs)
- Injection drug users (IDUs)
- Women with high risk partners

Priority Interventions. In this planning year, the IPPG focused on prioritizing interventions for MSMs. In 2000-2001, the group will assess the needs of and prioritize interventions for women with high risk partners, and in 2001-2002 the IPPG will address IDUs.

Interventions for MSMs. In prioritizing interventions for MSMs, the IPPG considered these factors:

- Idaho's HIV epidemiological profile.
- MSM needs assessment data and gap analysis.
- Research on effective interventions.
- Behavioral theories on which good interventions are based.
- Input from Regional HIV Prevention Councils.
- The varied social, demographic and political environments in each health district.
- The prevention resources available in each health district.

The IPPG determined that five types of interventions for MSMs should be implemented in Idaho: individual level interventions, group level interventions, prevention case management, outreach, and counseling and testing.

However, given the significant differences in the resources, political and religious environments, and population size and make-up of Idaho's seven health districts, the IPPG decided not to name specific prevention activities to be implemented under each intervention type. Instead, the IPPG wishes to allow each of the health districts to choose and tailor interventions that best fit their unique communities and resources. In other words, one specific intervention will not fit all areas of the state.

At the same time, the IPPG stated that any intervention implemented must have evidence of proven effectiveness and/or be based on sound behavioral theory. The IPPG further decided that the districts should receive technical assistance in identifying potential interventions to implement.

The IPPG also recommended that Health Districts 3, 5, and 7 receive technical assistance to build their capacity to implement interventions that effectively reach MSMs. These rural, conservative districts do not yet have strong connections developed with MSMs in their areas, nor do they have community-based providers in place to carry out individual and group level

prevention strategies. The primary HIV prevention resource in these districts are the health departments, which have historically done community level prevention education and counseling and testing.

1. Individual level intervention. This type of intervention is designed to reach MSMs at high risk of HIV infection. The one-on-one service offers counseling, assists clients in assessing their own behavior and planning individual behavior change, supports and sustains behavior change, and facilitates linkages to services in clinic and community settings. Through individual intervention, clients are assisted in building their skills and abilities to practice safer sex behavior and decrease the transmission of HIV.

This intervention uses the stages-of-change model of behavior theory by tailoring its approach to MSMs who are at different stages of readiness to change their behavior: precontemplation, contemplation, preparation, action, and maintenance. Its approach is also based on the theory of reasoned action which deals with the relations among beliefs, attitudes, intentions and behaviors. Behavior will change if the cognitive structure underlying the behavior changes at one or more of four levels: intention to perform the behavior, personal attitudes and social factors that affect the intention to perform, perceived positive outcome underlying attitude, and normative beliefs and motivation to comply with these norms.

This will be the first year that individual interventions for MSMs are formally organized and offered in Idaho. The STD/AIDS Program anticipates that HIV prevention providers in at least two health districts will build their capacity to implement individual intervention projects. These organizations will develop service protocols, identify qualified staff, and develop individual intervention plans specific to their district's prevention needs and resources.

2. Group level intervention. This health education/risk reduction intervention provides education and support in a group setting to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change to persons at increased risk of becoming infected, or if already infected, of transmitting the virus to others. Group interventions with MSMs allow individuals to hear and learn from one another's experiences, role play with peers, and offer and receive support. This type of intervention has been proven to reduce instances of high-risk sexual behavior among MSMs and increase condom use.

Multiple group sessions work to increase MSMs' knowledge levels about risk of sexual activity, improve self-management skills around self-identified risk situations, and increase peer support for behavior change. The facilitated groups target these factors in behavior change: attitudes, perceived norms, perceived risk, and self-efficacy. Group level interventions utilize the social influence model by which social norms and community membership influence and reinforce safer sex practices; and the social cognitive learning theory, by which a person's safe sex behaviors change because the person thinks the safer sex behaviors will lead to positive rather than negative outcomes, and the person believes he is capable and confident of carrying out the safer sex behaviors.

Very few group level interventions for MSMs are formally organized and offered in Idaho. In the Year 2001, the STD/AIDS Program anticipates that HIV prevention providers in at least four health districts will build their capacity to implement group intervention projects. These organizations will develop group level intervention plans specific to their district's prevention needs and resources.

3. Prevention case management. This intervention is an intensive client-centered prevention activity which assists HIV seropositive, as well as very high risk seronegative persons, in adopting risk-reduction behaviors. The service is intended for MSMs with multiple, complex HIV risk-reduction needs, having difficulty initiating or sustaining practices that reduce or prevent HIV transmission. These persons need highly individualized and intensive support and counseling, and substantial psychosocial interpersonal skills training. Trained counselors assess a client's knowledge about risk, perceived personal vulnerability, behavior change intention, self-efficacy, skill level, reinforcement of behavior change efforts, and environmental barriers. Prevention case management also assists individuals with accessing needed medical, psychological, social services.

Prevention case management has seven components: recruitment; screening and assessment; development of a prevention plan; multiple session risk-reduction counseling; coordination of services with follow-up; monitoring and reassessment of clients' needs, risks, and progress; and case closure upon attainment of goals.

The STD/AIDS Program anticipates that HIV prevention providers in at least two health districts will build their capacity to implement prevention case management. These organizations will develop service protocols, identify qualified staff, and develop prevention case management plans specific to their district's prevention needs and resources. Standards outlined in CDC HIV Prevention Case Management Guidance will be followed.

4. Outreach. This health education/risk reduction intervention reaches a greater number of MSMs than individual and group interventions, but with a shorter duration. Outreach is conducted in settings where MSMs can be reached in the community. Through face-to-face outreach, MSMs are provided prevention messages and informational materials on HIV. Condoms are also distributed, and MSMs are assisted in obtaining primary and secondary prevention services.

The STD/AIDS Program anticipates that HIV prevention providers in all seven health districts will conduct outreach activities. There are several models proven to be effective for outreach to MSMs. These include the use of trained peers, such as the Friend-to-Friend program in Washington, and the use of popular opinion leaders in the MSM community. Each health district will adapt an outreach approach that best addresses their region's HIV prevention needs and makes the best use of their prevention resources.

5. Counseling, testing, referral and partner notification. HIV CTRPN will continue to be conducted at all seven health departments. Off-site testing will also be expanded to reach

MSMs in community settings. Current off-site testing locations include substance abuse treatment centers, jails, community events, bars, clinics, and homeless shelters.

Interventions for Women At-Risk. The IPPG decided to continue with the same interventions named in Idaho's last Comprehensive Prevention Plan. As noted above, in Year 2001, the IPPG will review needs assessment information specific to the prevention needs of women at-risk and prioritize new interventions at that time for inclusion in the state's Year 2002 application. Interventions that will be continued for the Year 2001 include the following:

1. Conduct a public awareness campaign to make women more aware of their own risk factors for HIV infection.

This community level health communications/public information intervention is intended to change hetero and bisexual women's behavior of unprotected vaginal and anal sex with high risk partners. The effort will also improve knowledge about HIV/AIDS prevention and transmission, increase women's awareness of their risk and increase the perception of risk among women engaged in high risk behaviors.

The community awareness campaign will reach women through various community settings where women, including adolescent females and women of color, either seek services or conduct business – such as STD/pregnancy clinics; Women, Infant and Children's Programs; substance abuse treatment centers; migrant and tribal health clinics; women's crisis shelters; day care centers; laundromats; beauty salons; grocery stores; and hospitals.

Messages will be targeted to women who have high risk partners: men who also have sex with other men, men who are IDUs, or men who are HIV+. Existing national prevention materials for women will be adapted for Idaho, and will include posters, brochures, and other print media.

2. Offer HIV risk assessment, counseling, testing, referral and partner notification at specific settings which offer health care services to women at-risk.

This CTRPN intervention is intended to change hetero and bisexual women's behavior of unprotected vaginal and anal sex with high risk partners. The service will also increase knowledge of HIV prevention and transmission and accessibility of condoms.

The intervention will utilize community health care resources which are already reaching females who are having unprotected sex. Clinics offering STD and pregnancy services are proven to be effective settings for offering HIV prevention services to women. Other agencies will include substance abuse treatment centers, primary care clinics, tribal health services, migrant health clinics, and homeless shelters. Through the use of an Idaho HIV risk assessment tool, these health care practitioners will identify women at-risk and offer CTRPN services. They will also distribute condoms.

3. Educate professionals who work with women at-risk to improve their knowledge of HIV prevention, and skills in respectful client counseling that supports change of risky behaviors.

This capacity building strategy is intended to expand health education/risk reduction efforts in Idaho. By educating others who work with women at-risk of HIV infection, HIV prevention resources and intervention activity will be increased. Professionals in the health care, social services, and criminal justice fields will be trained to reinforce safer sex practices among women who have high risk partners, who are having unprotected sex, or are IDUs. The intervention is intended to decrease the incidence of unprotected sex, increase the women's knowledge of HIV prevention and transmission, and improve skills in communication with partners on safer sex.

Professionals will be offered training in assessing, educating and counseling adolescent females on HIV prevention and transmission, use of condoms, and other safer sex practices.

Interventions for IDUs. The IPPG decided to continue with the same interventions named in Idaho's last Comprehensive Prevention Plan. As noted above, in Year 2002, the IPPG will review needs assessment information specific to the prevention needs of IDUs and prioritize new interventions at that time for inclusion in the state's Year 2003 application. Interventions that will be continued for Year 2001 include the following:

1. Educate substance abuse treatment providers on HIV risk assessment and prevention.

This capacity building strategy is intended to expand individual health education/risk reduction efforts with IDUs in Idaho. HIV prevention providers in the districts will contact substance abuse coordinators at local schools, juvenile detention centers, and substance abuse prevention and treatment centers to discuss and provide resources on risk reduction of HIV for IDUs. By educating others who work with IDUs at-risk of HIV infection or are HIV+, HIV prevention resources and intervention activities will be increased. Substance abuse treatment providers will be trained to reinforce the behaviors of clean needle use and safer sex practices among the IDUs they serve. This effort will include education and coordination of prevention resources with substance abuse workers at migrant health clinics and tribal health programs.

2. Expand the availability and accessibility of CTRPN.

Each health department will be asked to work through the regional HIV Prevention Advocates and Regional HIV Prevention Councils to develop innovative ways of making CTRPN more accessible to the IDU community, such as testing off-site of the health department offices, and expanding counseling for IDUs who are HIV+. Expansion of CTRPN to IDUs will include the provision of accessible and appropriate services through migrant health clinics and tribal health programs.

3. Research pharmacy policies regarding purchase of syringes over-the-counter.

Needle exchange programs, though shown to be effective, are not feasible to implement with public funds in the state of Idaho. However, a potential source of clean needles is direct purchase from a pharmacist. During 2001, regional HIV Prevention Advocates will work with their Regional Prevention Councils and the IPPG's IDU Committee to interview local pharmacists on their policies regarding sale of syringes, and provide education on the importance of clean needles to the reduction of HIV transmission, with the intent of having as many pharmacists as possible making individual syringes available.

4. Develop an outreach program to distribute condoms, personal responsibility kits, and HIV prevention information to IDUs.

This outreach intervention will be implemented during 2001. Community-based outreach programs using peer and trusted non-peer outreach workers has been shown to increase use of clean needles and to increase the use of condoms among IDUs. The regional HIV Prevention Advocates will identify local liaisons with the IDU community who can in turn disseminate messages about prevention of HIV infection and distribute personal responsibility kits and condoms. Condom distribution to IDUs will also continue through other outlets, such as substance abuse treatment centers and health clinics.

LINKAGES

Secondary Prevention. At the state level, the Idaho STD/AIDS Program administers the HIV Prevention Program, the Ryan White CARE Program and the AIDS Drug Assistance Program. In this role, the STD/AIDS Program works to build the capacity of communities to offer both primary and secondary HIV prevention services. Program staff assess coordination needs, train community staff, and provide guidance to providers of primary and secondary HIV prevention services. Given the limited infrastructure of Idaho's HIV/AIDS-related services, primary and secondary HIV prevention services are often provided by the same organizations at the local level. Idaho's health departments provide HIV testing, prevention counseling, post-test counseling and case management for individuals with HIV in all seven health districts. The Boise-area health district (Central District Health) and Family Practice Residency Clinic house the region's only Ryan White Title III AIDS clinic. The Idaho AIDS Foundation conducts HIV prevention peer counseling, HIV counseling and testing, public information projects, food bank/supply bank and support services for persons living with HIV/AIDS.

Idaho's confidential HIV counseling and testing protocol requires that clients complete a risk assessment which includes pre- and post-test counseling: obtaining written consent to test, establishing/improving the client's perception of risk, identifying and supporting behavior changes, negotiating a plan to reduce risk, conducting cost benefit analysis, giving and interpreting test results and reinforcing plans to reduce risk.

Because of Idaho's small size, linkages naturally occur for all areas of HIV/STD prevention and risk reduction. All services are delivered by the same mixed group of health care professionals allowing for a natural flow between services and activities. The state has seven HIV Prevention Advocates (five of which also serve as HIV Care Managers) and one full-time case manager who insure the smooth movement of clients between primary prevention services and secondary services. The Advocates are directly responsible for outreach interventions in each of their areas and serve as the "point person" for HIV prevention to the target populations.

STD Treatment, Ryan White CARE Act. HIV Prevention, HIV/AIDS Surveillance, STD Control, and Epidemiological Services are all located in the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services. HIV Prevention, STD Control, and HIV/AIDS Surveillance are all managed by the same person. The programs have worked together for many years, sharing data and planning surveillance and prevention activities. Examples of cross-program activities are listed below:

- The Comprehensive STD Program Specialist also works HIV case investigations and coordinates with the HIV/AIDS Surveillance Specialist and district health staff responsible for local CTRPN activities.

- The HIV/AIDS Surveillance Specialist is also responsible for the Ryan White CARE Program (Title II) and works with local part-time case management staff on early intervention services for newly HIV-infected persons.

- STD and HIV/AIDS case registries are routinely cross-referenced as needed to comply with state law related to reporting and treatment of communicable disease.

- Epidemiologic Services publishes a quarterly bulletin, Idaho Disease Bulletin that often includes cross program information. The Bulletin is distributed to all Idaho physicians and other health care practitioners and organizations.

- STD and HIV staff in local district health departments are fully integrated with family planning services in many regions. TB control staff and district HIV/STD epidemiologic staff work together on common client investigations and follow-up.

- Community planning efforts have further enhanced the coordination between the HIV/AIDS Surveillance and Prevention Programs. The HIV/AIDS Surveillance Specialist is a non-voting member of the Idaho HIV Prevention Planning Group and presents Idaho's Epidemiologic Profile for discussion during community planning sessions.

Substance Abuse Prevention and Treatment. The STD/AIDS Program and the State of Idaho Substance Abuse Prevention and Treatment Program are housed in the same building one floor apart. Both programs are components of the Department of Health and Welfare and work together within the regional health districts in joint projects though family planning clinics, alternative test sites at substance abuse treatment providers, and a joint venture in substance abuse counselor training through the state university system. At the district level, the HIV Prevention Advocates have developed linkages with corrections facilities to conduct HIV prevention outreach work.

Reproductive Health Care Services. Health department clinic sites across our rural state have integrated STD, HIV, and reproductive health services into the same location. This allows for good coordination and quick referral for an individual needing more than one service. The STD/AIDS and Reproductive Health Program Managers both work in the Division of Health's Bureau of Clinical and Preventive Services and have regular discussions on program collaboration.

GOALS

PROJECT PERIOD GOALS

Counseling, Testing, Referral, and Partner Notification (CTRPN)

By December 31, 2003, individuals who engage in behaviors that place them at risk for HIV infection will receive counseling, testing, referral and partner notification services.

Health Education/Risk Reduction

By December 31, 2003, health education/risk reduction activities targeting the priority populations will be implemented in the seven district health regions of the state.

Public Information Programs

By December 31, 2003, the STD/AIDS Program will implement population specific media campaigns targeting those individuals who engage in behaviors that place them at risk of HIV infection.

Evaluation & Research

By December 31, 2003, the STD/AIDS Program will develop and implement a comprehensive evaluation plan for evaluating various components of community planning and HIV prevention supported with cooperative agreement funds.

HIV Prevention Capacity Building Activities

By December 31, 2003, the STD/AIDS Program will support local infrastructure and capacity building activities that will result in an increased quality response to HIV prevention in Idaho.

Training & Quality Assurance

By December 31, 2003, the STD/AIDS Program will continue to build the capacity of health care providers and health educators that will result in effective HIV prevention activities.

By December 31, 2003, the STD/AIDS Program will develop and implement a plan to address quality assurance mechanisms with program contractors.

ONE YEAR GOALS

MSM Priority Population

By December 31, 2001, 50 MSMs at high risk of HIV infection will receive individual counseling and support that will build their skills and abilities to practice safer sex behavior.

By December 31, 2001, group level interventions in at least four health districts will reach 200 MSMs with education, skills training and support that will increase MSMs' knowledge levels about risk of sexual behaviors, improve self-management skills around self-identified risk situations, and increase peer support for behavior change.

Be December 31, 2001, 30 HIV seropositive MSMs in at least two health districts will receive prevention case management services that will assist them in adopting and maintaining risk-reduction behaviors.

By December 31, 2001, through outreach activities statewide, 500 MSMs will receive prevention messages, condoms, and informational materials on HIV.

By December 31, 2001, 300 MSMs statewide will be provided HIV testing as well as pre- and post-test counseling.

Women at-Risk Priority Population

By December 31, 2001, the STD/AIDS Program and its prevention partners will conduct a statewide media campaign that will raise the awareness of women about their risk of HIV infection.

By December 31, 2001, 500 women with high risk partners will receive counseling and HIV testing services at testing sites that offer other reproductive health services for women.

By December 31, 2001, the Idaho STD/AIDS Program and its prevention partners will provide educational and training to professionals working with women at-risk on reinforcing safer sex practices of these women.

IDU Priority Population

By December 31, 2001, the STD/AIDS Program and its prevention partners will provide education and training to professionals working with IDUs on reinforcing safer needle use and safer sex practices of IDUs.

By December 31, 2001, 600 IDUs will receive counseling and HIV testing services at sites that are accessible to this target population.

By December 31, 2001, the attitudes of pharmacists regarding sale of syringes to IDUs will be assessed, and education will be provided to pharmacists on their potential role in HIV prevention among IDUs.

By December 31, 2001, 50 IDUs will be reached through trained peer and non-peer outreach workers with messages about HIV prevention and will be provided personal responsibility kits and condoms.

SURVEILLANCE AND RESEARCH

Surveillance. The STD/AIDS Program's HIV/AIDS Surveillance Specialist will continue to carefully document reported cases of HIV infection and AIDS in Idaho. Data profiling HIV and AIDS cases by district, age, race/ethnicity, gender, and risk factor will be published quarterly. The IPPG will be briefed annually on the profile of populations infected with HIV/AIDS in the state, and will review and revise its defined priority populations as needed, as well as interventions to those most at risk of infection.

COORDINATION AMONG AGENCIES AND ORGANIZATIONS

At the state level, the STD/AIDS Program contracts with a number of private, nonprofit organizations to carry out HIV prevention work. These include the North Idaho AIDS Coalition, Sojourner's Alliance, Idaho Migrant Council, Idaho AIDS Foundation, Mountain States Group, and NAACP. The STD/AIDS Program also meets regularly with other state level agencies with a stake in HIV/AIDS Prevention, such as the Department of Education and the Idaho Reproductive Health Program.

The state office also involves other organizations on its HIV/AIDS Joint Materials Review Panel, including representatives from the Idaho State Library, parents, rural high schools, a hospital's women's program, Idaho Department of Education, the faith community, and HIV prevention contractors.

At the community level, each of the seven health districts has a Regional Prevention Council with membership from a variety of public and private organizations, including the American Red Cross, public and private colleges and universities, YWCAs, Idaho Migrant Council, hospitals, tribal health representatives, home care service agencies, physicians, NAACP, mental health and substance abuse treatment providers, corrections, faith community, and district health departments. These links help assure the coordination of local efforts to prevent the spread of HIV.

The state STD/AIDS Program and local health districts also coordinate alternative testing sites with other organizations. These sites include substance abuse treatment centers, community health events, clinics, jails, homeless shelters, and bars.

TECHNICAL ASSISTANCE NEEDS ASSESSMENT AND PLAN

Evaluation. During CY2001, the STD/AIDS Program, IPPG, health district offices and community based prevention contractors will receive technical assistance on evaluating Idaho's HIV prevention program. The state has contracted with Boise State University to provide specific assistance in evaluating the community planning process, intervention plans, implementation of interventions, and linkages between the plan, application, and resource allocation.

By the end of 2001, the STD/AIDS Program will have an evaluation design in place to assess linkages between the comprehensive plan and interventions funded; prevention program implementation; and outcomes of HIV prevention efforts. By the end of the year, HIV prevention contractors will have an evaluation design in place to assess the implementation and outcomes of their HIV prevention interventions.

Rural HIV Prevention. In response to their request, during CY2001, IPPG members and HIV prevention contractors will receive information on HIV prevention models that have been researched and proven effective in other rural settings. IPPG and contractor representatives will attend the National Rural AIDS Conference, and the STD/AIDS Program will request information and resources from the Rural Center for AIDS/STD Prevention. Through this technical assistance, rural prevention strategies will be examined for their potential replication in Idaho.

Individual and Group Level Interventions. Idaho is shifting its prevention strategies more toward individual and group level strategies, and giving less emphasis to community level and public information efforts. Several rural health districts in Idaho will require technical assistance to build their capacity to carry out these types of interventions. At least three health districts will be provided assistance in developing stronger links with priority populations, designing interventions that fit the needs of these populations, and building staff and organizational structure to implement individual and group level interventions.

The technical assistance needs of IPPG members and HIV prevention providers will continue to be assessed at least twice during CY2001 through a written survey. In addition, technical assistance needs will be assessed more informally throughout the year through meetings and discussions with IPPG committees and with HIV prevention contractors.

COMMUNITY PLANNING EVALUATION PLAN

The STD/AIDS Program, Mountain States Group, and the IPPG Evaluation Committee will annually evaluate how well Idaho's community planning process is achieving the five core objectives of HIV prevention community planning. First, we will survey all IPPG members using the CDC's "CPG Member Survey" form. During 1999 and 2000, this proved to be a useful tool to gather information about members' perceptions of the planning process.

Together the state and the IPPG will review survey results and determine how community planning might be improved.

We will also document and evaluate whether all the required steps of community planning have been accomplished:

1. Recruiting group members who are representative of the groups affected by the epidemic.

2. Ensuring that the planning process is open and participatory.

3. Conducting a needs assessment, resource inventory, gap analysis, and intervention inventory.

4. Compiling an epidemiologic profile.

5. Prioritizing needs and target populations based on the needs assessment and epidemiological profile.

6. Developing a comprehensive HIV prevention plan that reflects those priorities.

7. Selecting and funding activities that correspond to the plan.

Finally, the IPPG and the state will evaluate whether the five core objectives of community planning are being met.

1. Fostering the open and participatory nature of the community planning process.

2. Ensuring that the community planning group reflects the diversity of the epidemic in the state, and that experts in epidemiology, behavioral science, health planning, and evaluation are included in the process.

3. Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.

4. Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

5. Fostering strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources.

This will be evaluated through review of our member recruitment process, our membership composition, bylaws, needs assessment process, prioritization process, and plan review by the IPPG.

LETTERS OF CONCURRENCE

IPPG Co-Chair letters of concurrence are attached to the STD/AIDS Programs 2001 HIV Prevention application to the CDC.